THE CONTEXTS AND COMPLEXITIES OF COMMUNITY PARTICIPATION:

STRENGTHENING VILLAGE HEALTH, SANITATION, AND NUTRITION COMMITTEES IN RURAL NORTH INDIA

by
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Abstract

The Indian government's Village Health, Sanitation, and Nutrition Committee (VHSNC) program seeks to improve rural access to the fundamental entitlements of public health. Although over 500,000 VHSNCs have been officially formed, they have so far failed to serve as viable local bodies. In 2013, the government introduced guidelines to invigorate VHSNCs.

This dissertation examines the contexts that facilitate and hinder VHSNC functionality, and explores the impacts of VHSNCs on marginalized communities and the non-governmental organizations (NGOs) that support them. The study draws on longitudinal qualitative research from rural north India.

The study found that contextual features at the community, health facility, health administration, and societal level were often at odds with VHSNC functionality. Despite challenges at the community level, inclusive VHSNCs were formed, and the members received training, held monthly meetings, and attempted to improve local public services. However, barriers in the other contextual spheres undermined committee capacity to bring concrete improvements (chapter 5).

VHSNCs created some opportunities for participants to re-negotiate power inequalities within the community, particularly around gender. Power inequalities between the communities and outside actors (e.g. government officials) were

manifest in a "discourse of responsibility," whereby outsiders sought to assign broad responsibility for improving public services onto VHSNCs. Some community members accepted this discourse and then blamed their peers for failing to take action, entrenching a negative collective identity. Others rejected the discourse, and positioned participation in the VHSNC as futile, since responsibility lay beyond VHSNC control (chapter 6).

The NGO that implemented the VHSNC-intervention played a crucial role in building community capacities to engage with government and helped overcome many community-level barriers to participation. These beneficial processes were made possible by the NGO's "in-between status" as community advocate and government helper. Yet this role came at a high cost for NGO staff, who found themselves promoting VHSNCs with little control over key factors that influenced the program (chapter 7).

This study highlights the urgent need for supportive contexts in which people can not only participate in health committees, but also access the power and resources needed to bring about actual improvements to their health and wellbeing.

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List of abbreviations

ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
AWC	Anganwadi Centre
AWH	Anganwadi Helper
AWW	Anganwadi Worker
BC	Backward Caste
BCMO	Block Chief Medical Officer
BDO	Block Development Officer
CDPO	Child Development Project Officer
CHC	Community Health Centre
CMHO	Chief Medical Health Officer
CSR	Corporate Social Responsibility
FGD	Focus group discussion
GO	Government Order
HSC	Health Sub Centre
ICDS	Integrated Child Development Service
IDI	In-depth interview
JSY	Janani Suraksha Yojana
LMICs	Low and Middle Income Countries
MNREGA	Mahatma Gandhi National Rural Employment Scheme
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MoWCD	Ministry of Women and Child Development
MPW-M	Multi-Purpose Worker—Male
NGO	Non-Governmental Organization
NHSRC	National Health System Resource Centre
NRHM	National Rural Health Mission
OBC	Other Backwards Caste
PHC	Primary Health Centre
PHED	Public Health Engineering Department
PHFI	Public Health Foundation of India
PRI	Panchayat Raj Institution
PWD	Public Works Department
SBC	Special Backwards Class
SC	Scheduled Caste
SDM	Sub Divisional Magistrate
SHG	Self-Help Group
ST	Scheduled Tribe
TB	Tuberculosis
VHC	Village Health Committee
VHSNC	Village Health, Sanitation and Nutrition Committee
WHO	World Health Organization

CHAPTER 1. INTRODUCTION

1.1 Introduction

Primary health care, basic sanitation, and adequate nutrition form the bedrock of public health, yet billions of people in low and middle income countries (LMICs) lack access to these basic entitlements (WHO 2008; Bhutta et al. 2011; Murray and Lopez 1997). Inaccessible health services, inadequate sanitation, and poor nutrition continue to cause high rates of avoidable illness and death among the poor (Black et al. 2008; WHO 2015a; Scrimshaw and SanGiovanni 1997; Benova, Cumming, and Campbell 2014). For example, the deaths of 3.1 million children under five in 2011 (45% of all under-five child deaths that year) were rooted in undernutrition, which interacts synergistically with infection due to poor sanitation and escalates due to insufficient health care (Black et al. 2013). The vast majority of the 280,000 maternal deaths in 2013 occurred in LMICs and were rooted in a lack of basic health care, exacerbated by unsanitary conditions and maternal undernutrition (Kassebaum et al. 2014).

Although decades of national and international policy and programs have enabled great improvements, there are still far too many gaps (WHO 2015a). A vast range of inter-connected factors contribute to whether basic public health interventions reach the people who need them, including political issues of prioritization and

governance, implementation issues of management and scalability, and community issues of engagement and trust.

Village health committees, composed of community members and frontline public system functionaries, have emerged as one strategy to address many of these factors, for example by bolstering public sector accountability, generating local resources, and deepening community engagement (Molyneux et al. 2012; McCoy, Hall, and Ridge 2011). While there is evidence that these committees have the potential to strengthen public systems and ultimately improve health (Loewenson, Rusike, and Zulu 2004b; Sohani 2005; Bjorkman and Svensson 2009; Iwami and Petchey 2002b; Manandhar et al. 2004), a positive impact is by no means guaranteed (Azad et al. 2010). I present more detail on the historical context of community participation and health committees in the next chapter. Research into how specific contexts bolster or hinder committee functionality and how these committees are experienced by the communities in which they operate is vital to develop better health committee support strategies.

This dissertation examines India's Village Health, Sanitation and Nutrition Committees (VHSNCs), a program that seeks to improve rural access to the basic rights of health, sanitation, and nutrition on a massive scale. Since the program's launch in the mid-2000s, VHSNCs have been officially formed in over 500,000 villages and have ostensibly involved at least 3.5 million members (MoHFW India 2013a). However, these committees have not reached their potential as robust

institutions for community engagement in public health. Members often do not know their roles, composition rarely adheres to guidelines, meetings are often irregular and poorly attended, many committees are entirely dormant, and there is often negligible participation in budgeting or developing village health plans (Bajpai, Sachs, and Dholakia 2009; PHRN 2008; R. Singh and Purohit 2012).

In response to their initial lackluster performance, the Indian government developed *Guidelines for Community Processes* (MoHFW India 2013a) to strengthen VHSNCs. Data for this dissertation are drawn from a 1.5-year study (2014-2015) that examined the implementation of a draft version of these guidelines in 50 villages in rural northern India.

1.2 Study aims

The aims of this study were to:

Aim 1: Describe social and political conditions that facilitate and hinder VHSNC functionality.

Aim 2: Understand how power inequalities operate through the VHSNC to create social costs and opportunities for community participants.

Aim 3: Explore the experience of a local non-governmental organization (NGO) implementing the VHSNC support package, to identify the struggles, strategies, and trade-offs that arise from working between communities and government.

1.3 Organization of the dissertation

This dissertation is organized into eight chapters. This first chapter introduces the study. In chapter 2, I present an overview of the literature on community participation in health and village health committees, as a specific vehicle for community participation. In chapter 3, I discuss the Indian and local north Indian context. In Chapter 4, I present the study design and data collection.

Chapters 5, 6 and 7 consist of three manuscripts that I will be submitting for publication to peer-reviewed journals. Chapter 5 examines the interplay between context and VHSNCs, highlighting that the capacity of these committees to bring about changes in the health system and sustain community interest was hindered by incomplete decentralization, a severely under-resourced health system, poor intersectoral collaboration and unclear hierarchies of responsibility. Chapter 6 explores the social costs and opportunities born by communities, as power inequalities are mediated through the "social space" of the VHSNC. Chapter 7 explores how the NGO that implemented this community engagement intervention was placed in the challenging position of seeking to retain community trust while serving as a "government helper."

I conclude in chapter 8 with an overall summary of the results, examining how this research can inform the village health committee program in India and discussing the implications of my findings for community participation in health more broadly.

CHAPTER 2. LITERATURE REVIEW

2.1 Community participation in health

Communities can be understood as groups of people who, despite being heterogeneous, share (1) an identity, (2) a set of social representations (symbols, knowledge, aspirations) and (3) conditions and constraints of access to power (Campbell and Jovchelovitch 2000; Howarth 2001). These traits are most frequently manifested among people who share a common geographical space, such as those in villages. Community is the means through which individuals integrate into society and the means through which society constructs individuals (Howarth 2001). Although communities are sites where damaging social relations and forms of social exclusion are reproduced, they can also be sites of empowerment, where unequal relations can be challenged and resisted (Joffe 2003; Howarth, Foster, and Dorrer 2004). Theories of community empowerment draw upon the ecological approach to community development, which moves beyond seeing community as "lots and lots of people" to an "ecosystem with capacity to work towards solutions to its own community identified problems" (Hawe 1994).

Community participation has been promoted as an essential feature of primary health care since the landmark Alma Ata conference on primary health care in 1978. The Alma Ata declaration on primary health care stated that "people have the right

and duty to participate individually and collectively in the planning and implementation of their health care" (WHO/UNICEF 1978). Attempts to enable people to realize this "right and duty" have frequently manifested in community mobilization processes, which can be usefully defined as:

> … A capacity-building process through which community members, groups or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other conditions, either on their own initiative or stimulated by others (Howard-Grabman and Snetro 2003, 3)

Rifkin (1996) suggested that engaging community members in planning and managing their health systems makes them more: (1) likely to access existing services and help sustain new services, such as community health worker programs; (2) able to offer material resources and manpower to support the minimal resources allocated for health care; (3) inclined to change their poor health behaviors when they have been involved in exploring the consequences of their behavior; and (4) prone to gain information and experience, thus allowing them to have greater control over their lives and challenge the existing political, economic and social system. Underpinning these outcomes is the idea that participation can be an emancipatory process, with benefits that include but go beyond specific health or health system outcomes. These broader emancipatory outcomes include increased

critical awareness of inequalities (or *conscientization*, as discussed by Freire (1973)) and ownership of health rights issues (Guareschi and Jovchelovitch 2004; Zakus and Lysack 1998). Robert Chambers (1994) further argued that many social programs failed to bring about positive changes in marginalized communities because they were developed by urban elites who did not understand local needs and realities. He therefore called for bottom-up development based on participatory learning and action techniques designed to "enable local people to share, enhance and analyze their knowledge of life and conditions, to plan and to act" (Chambers 1994, 1253).

Despite significant enthusiasm for community participation in health systems, the process has been complex and often failed to achieve its potential (Cueto 2004; Rifkin 2014). Power inequalities within communities can lead participatory interventions to disproportionately or exclusively benefit local elites and at times even harm the most marginalized (Guijt and Kaul Shah 1998; Mosse 1994; Meinzen-Dick and Zwarteveen 1998; Wilkes 2000). For example, Mosse (1994) noted that participatory processes in Tamil Nadu privileged male knowledge and expertise over female, as women lacked the ability to articulate their concerns in public and through acceptable mediums (e.g. maps and diagrams). In a Jamaican participatory program, the more educated and better-networked community members dominated decision making and were more likely to gain access to social investment projects that matched their preferences (Rao and Ibáñez 2005). In Kenya, the owners of slum housing in Nairobi found numerous ways to limit the influence of the more marginalized tenants; for instance, some structure owners insisted that their

tenants register the owners' name as residing in the property, in an attempt to block future land dispersal to tenants (Rigon 2014). Participatory interventions have been blamed for causing community burn out, competition within communities to benefit from interventions, sanctions against those who do not go along with mainstream processes, and the loss of credibility for community leaders who champion processes that fail to live up to expectations (Smith 2004; McTague and Jakubowski 2013; Katz, Cheff, and Campo 2015; Mosse 2001; Mosse 1994; Becher 2010).

Many researchers argue that these problems are linked to implementation failures, illustrating for example that development interventions bearing the label "participatory" frequently fail to truly pass control over to communities, with control being the process hypothesized to mediate between participation and improved well-being (Arnstein 1969; Naimoli et al. 2012; Rifkin 1996). Others reject aspects of the philosophical underpinnings of this health and social development strategy. They note the high opportunity costs of participation, wherein participants in poor communities who invest their limited resources into new initiatives can end up worse off if the intervention does not deliver the anticipated benefits (Cooke and Kothari 2001). Meinzen-Dick and Zwarteveen (1998) found that for many women in South Asia, the balance between costs and benefits of participation is often negative: for instance, complying with the rules and practices of water management groups involved considerable time costs and social risks, compared to obtaining irrigation services through informal, but less secure, means. More broadly, community participation has also been critiqued as a tool for neo-liberal economic practices,

specifically through legitimizing the reduction of public services and increasing the role of volunteerism within the social sector (Geddes 2006; O'Reilly 2011). Some suggest that participatory processes can distract marginalized groups from broader, systemic political issues by demanding excessive time and energy be focused on micro level issues (Harriss 2001; Fine 1999; Katz, Cheff, and Campo 2015).

Nonetheless, even those most critical of participation do not suggest abandoning it as a strategy (Mosse 1994; Cooke 2004). While it is challenging to measure definitive links to health outcomes, often because there is no standard definition of "community" and "participation," reviews nonetheless identify health improvements as a result of participation (Rifkin 2014; Atkinson et al. 2011; Prost et al. 2013; McCoy, Hall, and Ridge 2011). Instead, critical scholars stress that an acute awareness of participation's potential harms and pitfalls, positioned within careful consideration of power relations and stakeholder motivations to promote it, can enable a more considered engagement with this complex process (Kesby 2005a; Williams 2004; Mosse 1994; Hickey and Mohan 2004).

2.2 Health committees

The principle of community participation in health is often manifested through the formation of health committees. These committees can be defined as groups composed primarily of laypeople that take action to improve local health within the public system. Health committee activities often include supporting or overseeing

health centers or health workers, playing a role in public health budgeting, contributing to health-promotion activities such as immunization drives or health rights awareness campaigns, and supporting environmental health through, for example, vector-control or sanitation activities. The specific role and scope of village committees varies widely across contexts.

2.2.1 Evidence linking health committees to health and health system outcomes

McCoy, Hall, and Ridge's (2011) systematic review examined the factors that influence the performance and effectiveness of community health committees in LMICs. To be included in the review, studies had to use experimental or case control design. Only four studies met this criterion: a retrospective study on Local Committees for Health Administration (CLAS) in Peru (Iwami and Petchey 2002b), a case-control study of Health Center Committees (HCC) in Zimbabwe (Loewenson, Rusike, and Zulu 2004b), a before-and-after intervention study of Dispensary Health Committees (DHCs) in Kenya (Sohani 2005) and a randomized case-control study of Health Unit Management Committees (HUMC) in Uganda (Bjorkman and Svensson 2009). All four found improvements in health service quality and coverage as well as health outcomes.

In Peru, CLAS facilities did better than non-CLAS facilities on a number of measures including user satisfaction and access for the poorest (Iwami and Petchey 2002b). In Zimbabwe, the HCC wards compared to non-HCC wards showed a higher likelihood

of health service use for the last illnesses, greater use of antenatal care, fewer cases of diarrhea, greater use of oral rehydration salt therapy, more staff, better community health indicators (health knowledge, health practices, and use of health services), and stronger links between communities and health workers (Loewenson, Rusike, and Zulu 2004b). In Kenya, when comparing indicators before and after the implementation of DHCs, Sohani (2005) reported that health care utilization and revenue generation increased, weekend outreach services for the most distant villages were initiated, medicines became more readily available, village health workers were revitalized, and leakage of funds and financial mismanagement were reduced. The Uganda intervention, which bolstered the performance of HUMCs (in many cases dissolving pre-existing committees and electing new ones), also showed impressive results. The intervention communities compared with the control communities had significantly improved immunization and vitamin A supplementation coverage and higher clinic utilization for general outpatient services, deliveries, antenatal care and family planning. Most remarkably, children born in the intervention areas in 2005 had a 35% lower likelihood of death compared to children born in the control villages (Bjorkman and Svensson 2009).

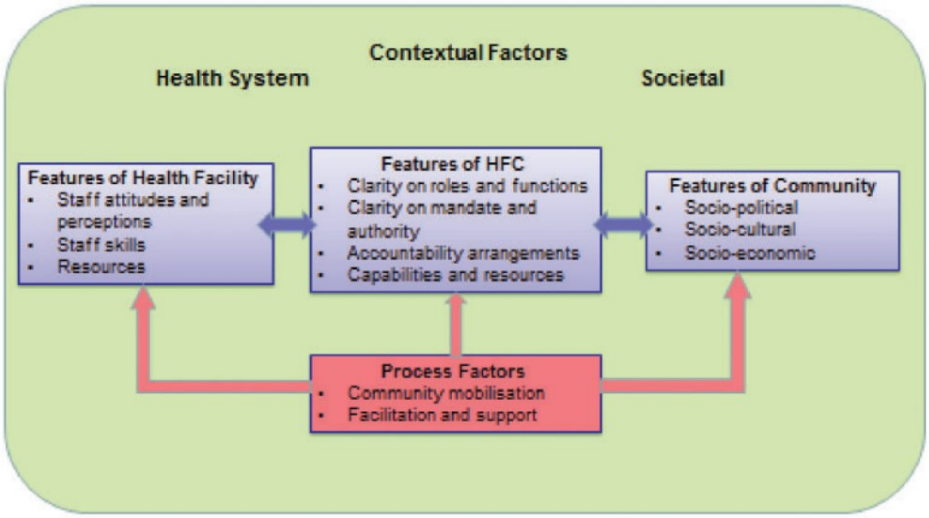
In a systematic review on community accountability in peripheral health facilities, Molyneux et al. (2012) report that local committees are the most widely documented accountability mechanism. Village health committees and groups were the focus of 19 of the 21 papers identified, with some information on their implementation or impact from a wide range of countries including Kenya, Uganda,

Tanzania, Niger, Nigeria, Benin, Zambia, South Africa, Peru, Mexico, Cambodia and Nepal. The outcomes of these interventions were mixed. In Bolivia, corruption declined where local oversight groups were active (Gatti, Gray-Molina, and Klugman 2002). However in Uganda, some health management committees actually added to the problem by expropriating drugs themselves (McPake et al. 1999). Molyneux et al. conclude that the evidence base on how community accountability mechanisms operate and influence health services remains limited, and that there is a particular dearth of literature on the depth of community involvement. They emphasize that very little has been documented on the extent to which committees move beyond providing information to consultation, representation, and actual influence over health-related decisions.

2.2.2 Contextual factors influencing health committees

McCoy et al. (2011) and more recently George et al. (2015) examined contextual factors that influence health committee performance and effectiveness. McCoy and colleagues developed a framework for describing contextual features at the societal/community, health systems/facility and committee levels (Figure 1).

Figure 1: McCoy et al.'s conceptual framework of determinants of health facility committee performance



George et al.'s framework focused on contextual factors most relevant to health committees at the societal, health administration, health facility and community level. Both frameworks highlight the multiple levels of factors that influence health committee effectiveness and both studies highlight the interconnected nature of these levels. McCoy et al. delineated features of the health facility committee itself, noting that committees were more effective when there was clarity about their role, mandate, and authority. Establishing the appropriate balance of authority and accountability was central: when committees had too much power they could end up interfering with the day-to-day functioning of hospitals; without discretionary power to reward and discipline health workers they were found to have little capacity to improve health worker performance. Similarly, committees could be quickly frustrated and discouraged when they were constrained by having to

comply with directives from above or when large portions of their funds were earmarked already.

At the interface between communities and health committees, both reviews emphasize the importance of the committee selection process to ensure the members are seen as legitimate representatives. Closely linked to the formation process are issues of community awareness of the committee and community trust in the health committee members' motivation; in many papers, a lack of awareness and community skepticism undermined health committee influence and value (Falisse et al. 2012; Ngulube et al. 2004; Macwan'gi and Ngwengwe 2004; Mubyazi, Mushi, Shayo, et al. 2007; Sepehri and Pettigrew 1996; Meier, Pardue, and London 2012). In Kenya, Goodman et al. (2011) found that local people often elected respected elders who lacked the literacy to effectively handle budget duties. In Uganda, public participation in committees was undermined by local political processes. Kapiriri et al. (2003) found that elected political leaders dominated planning and priority setting and did not communicate with or consult community members.

At the health facility level, some committees were primarily used as tools for health workers to meet their targets rather than avenues for community oversight or engagement (Leppard et al. 2011; Falisse et al. 2012). Many health committees were unable to improve health worker performance or bring about community-driven changes because they lacked discretionary power to reward or punish staff

(Loewenson 2000a; Kapiriri, Norheim, and Heggenhougen 2003; Mubyazi and Hutton 2003; Loewenson, Rusike, and Zulu 2005; Mosquera et al. 2001; Mubyazi, Mushi, Shayo, et al. 2007). A lack of formal support and capacity building from the health administration was a major factor that hampered the functionality of many committees (Meier, Pardue, and London 2012; Gurung and Tuladhar 2013; Collins et al. 2007; Zakus 1998; Iwami and Petchey 2002b; Boulle et al. 2008). Committees in Kenya struggled with the tension between local priorities and national health indicators: although committees were able to influence some targets and priorities, emphasis on national indicators left many local priorities unaddressed in final work plans (O'Meara et al. 2011). Goodman et al. (2011) found that while there were generally high levels of trust and collaboration between health facility workers and committee members, friction occasionally developed around sharing financial information and committee efforts to supervise the health care professionals.

At the community or societal level, committees are embedded within the political power structures and social norms of their environment, for example making it difficult to have genuine representation from women in areas where women are marginalized. Links to other community groups or to decentralized local systems of government could increase health committee legitimacy. The context of the wider health system shapes the space for community participation and specifies the committee's mandate, support, and funding. The levels of transparency in the larger system will shape committee effectiveness and transparency. NGOs often play an important role in improving health committee training and further the inclusion of

marginalized groups (Shukla, Scott, and Kakde 2011; Shepard 2006; Paxman et al. 2005; S. Singh, Das, and Sharma 2010; Raju, Rao, and Mutatkar 2008).

2.2.3 Health committee roles and activities in LMIC health systems

Village health committees play a wide range of roles in health systems, from specific efforts around one project or illness to broader health promotion and health system planning and management. In Kyrgyzstan, volunteers from pre-existing village health committees tested the iodine content of salt in households, local retailers, and wholesale markets. They were able to reach 65% of the households and, over the course of seven months, increase coverage of iodinated salt both in households and in retail shops by working with shopkeepers to stock only iodinated salt (Schüth et al. 2005). Committees have been formed specifically to manage water systems through maintaining pumps and collecting user fees (O'Reilly 2006) and managing arsenic removal systems (Sarkar et al. 2010).

Many committees manage some of the funds for peripheral health facilities. In a number of African countries, this financial management role for health committees arose from UNICEF/WHO's Bamako Initiative, launched in 1987. The initiative sought to decentralize health system financing and reduce donor and central government funding by instituting user fees and requiring patients to buy medicines (Ridde, Yaogo, et al. 2010). Health committees were introduced to manage the money brought in through user fees and drug sales, and more broadly oversee

primary health centers. In some countries (such as Kenya) user fees have since been reduced or replaced with budget transfers to the committees from the central government. In Kenya, facility management committees control many aspects of the local health budget under the Direct Facility Financing program. The Kenyan Ministry of Health transfers US $4500 per year to the committee for them to allocate according to local needs. A District Health Management team oversees the committee and places some limits on budgetary freedom (Goodman et al. 2011). In both Burkina Faso and Benin, village health committees continue to manage profits from drug sales and user fees for local operating costs, incentive bonuses to governmental health staff, and salaries for community managers of the essential drugs (Ridde, Haddad, et al. 2010; Ridde, Yaogo, et al. 2010).

Most health committees have a broad mandate and work across a range of areas including monitoring facilities, gathering resources from among the population, and promoting behavior change in the community. In Nigeria, Abimbola et al. (2015) found that community health committees demonstrated five modes of functioning including as a "village square" where people could meet to discuss issues, as "government botherers" who lobby the government for support, and as "government back ups" who augment public services. Uganda's health unit management committees (HUMC) oversee the running of the health units and district hospitals while the public health committees coordinate health issues, sensitize people, and gather information for planning (Kapiriri, Norheim, and Heggenhougen 2003).

Nepal's Village Development Committees (VDCs) and Health Facility Operation and Management Committees (HFOMCs) were developed during decentralization reform in the early 1980s (Bishai, Niessen, and Shrestha 2002; Gurung 2009; Morrison et al. 2005). VDCs are responsible for convening women's groups, conducting community health education, and providing resources such as immunization for polio and tetanus, vitamin A, iron and folic acid, ORS, and family planning (Morrison et al. 2011). They are considered the most active political institution in rural Nepal and contribute funding to rural health facilities (Bishai, Niessen, and Shrestha 2002). Morrison (2005) found that when supported by NGOs, pre-existing VDCs could successfully mobilize women's groups and collaborate to monitor all pregnancies and births in a region. Gurung (2009), however, reports that the locally formed HFOMCs failed to meaningfully involve women and lower caste people. Similarly, Bishai, Niessen and Shrestha (2002) found that only 8% of VDC members were female. In addition, committee training tends to focus on achieving tangible outputs such as developing infrastructure, hiring staff, and buying drugs, rather than building organizational capacity or community engagement.

2.2.5 Health committees in India

In India, a variety of committees have been constituted or bolstered by NGOs for interventions around specific health issues. Kamineni, et al. (2011) discuss working with health committees in Odisha state on sensitization and training around tuberculosis (TB) control. They report that NGO activities focused on TB issues "re-energized" the health committees, self-help groups, and local elected governments (called panchayats) to identify suspected TB cases and advocate for directly-observed treatment—short-course (DOTS) at the community level.

A number of leprosy-focused village committees have developed stigma reduction organizing committees and leprosy health resource centers across Uttar Pradesh, West Bengal, Orissa and Chhattisgarh (Porichha et al. 2011; Raju, Rao, and Mutatkar 2008; Raju and Rao 2011). The experiences of these leprosy groups were reported to have been mixed; overall the committees were active but meeting attendance rates fluctuated greatly (Raju, Rao, and Mutatkar 2008). Raju, et al. (2008) reported that ongoing NGO support was necessary to organize and sustain the leprosy committee activities.

Village water committees have been developed to maintain pumps and collect water tariffs from families through internationally-funded projects, such World Bank initiatives in Karnataka and Uttar Pradesh states (Stalker 2001) and an Indo-German water program in Rajasthan (O'Reilly 2006; Goyal 2005). Arsenic removal

in West Bengal has been effectively managed for over a decade by village committees (Sarkar et al. 2010). In the states of Jharkhand and Orissa, an intervention to promote maternal and newborn health through discussion-based women's groups reduced neo-natal mortality by 45% and moderate maternal post-partum depression by 57% (Rath et al. 2010; Tripathy et al. 2010).

Village health committees have also been established as part of the Local Initiatives Program for reproductive and child health services in Punjab, Himachal Pradesh, West Bengal and Uttaranchal (Paxman et al. 2005). The initiative established 620 reproductive and child health committees to stimulate community involvement in health care through locally developed work plans and local service delivery oversight. Paxman et al. reported that the committees offered local support for the initiative as well as vital connections with local government. By working closely with local government, committees were able to advocate more effectively for improved drug supply and staffing of health centers. In areas where village health committees already existed, the implementing NGOs made an intensive effort to bring these committees into the program. The authors note that allowing for variation in committee composition across contexts enabled the program to respond to the needs and histories of different states: the committees in West Bengal were made up of influential community members who were primarily businessmen, while in Uttaranchal the committees consisted of local government representatives, members of youth and women's groups, and social workers. In Punjab and Himachal Pradesh the committees included local leaders, many who

were women. At all sites the committees were responsible for recruiting and training volunteers, raising money, and enlisting support of local government and religious leaders. NGOs created or re-engaged existing health committees and trained members in leadership, management, and basics of reproductive and child health (Paxman et al. 2005). Committee functionality varied greatly: Some held health events for information dissemination, established clinics, and procured medicine and staff for their village clinics through linking with government doctors and nurses. However, other committees were less active, less cohesive, and less central to achieving project objectives. In these latter instances, the reproductive and child health objectives of the Local Initiatives Program were largely met through direct NGO efforts.

Since the mid-1990s, decentralization reform in India has encouraged panchayats to form standing committees of elected members on social services, including health and sanitation. Each state has articulated these reforms differently in their statutes, including variation in whether these committees are mandated or merely suggested. Research from the state of Tamil Nadu (Bajpai, Dholakia, and Sachs 2008, 36) found that although the constitution allows decentralization of the "system of governance in health to the multi layered local bodies," in reality their implementation "leaves much to be desired." Similarly, research in regions of Madhya Pradesh state (Behar and Kumar 2002) and Karnataka state (S. K. Ghosh, Patil, and Tiwari 2012) found that there were no active or known panchayat standing committees on health. One study presented a surprising contrast: research in 2001 in a district of West Bengal

found that the panchayat sub-committee members were convening monthly meetings in which immunization and family planning were commonly discussed and that many committees worked with health center staff to refer patients, arrange health camps, and improve environmental health (Barman 2006; Barman 2009). West Bengal's markedly different situation is likely explained by the fact that it, like the state of Kerala, has had long periods of rule by leftist parties, which promoted public welfare programs and decentralization (World Bank 2000a).

The literature highlights the prominent role that grassroots NGOs have played in forming and supporting health committees in India. Many issue-specific committees (leprosy, TB, reproductive health care, water) have been directly supported by NGOs (Raju, Rao, and Mutatkar 2008; Paxman et al. 2005; Goyal 2005; Kamineni et al. 2011). Even in the case of government-initiated committees, NGO efforts to strengthen these committees have proven highly successful (Shukla, Scott, and Kakde 2011; Stalker 2001; Khanna and Pradhan 2013; FRHS 2011).

Research specific to India's VHSNCs, as mandated in the National Rural Health Mission in the mid-2000s, is discussed in the next chapter (section 3.4).

CHAPTER 3. RESEARCH CONTEXT

3.1 Indian economic growth and social indicators

India is the world's second most populous country, with 1.25 billion people, and is considered a global emerging economy, due to the growth of its gross domestic product (GDP) by an average of 6% per year since the 1990s (World Bank 2015). GDP per capita has risen rapidly, from approximately US $302 in 1985 to US $1590 in 2015 (World Bank 2015). However, this massive increase in national wealth has been distributed in a strikingly unequal manner. The richest 20% of Indians now enjoy over 80% of the country's national income, while the poorest 20% get less than 1% (Credit Suisse 2014). And inequality in India has risen faster than almost anywhere else in the world (ibid). India's Gini coefficient, a common measure of income inequality, indicated a reduction and then stagnation in inequality from Independence in 1947 to 1990. However, it has tracked an increase in inequality since 1991, when the country shifted from socialist-inspired market policy to economic liberalization (Sarker 2009).

Basic public entitlements, such as health care, sanitation, and nutrition, remain out of reach for many. For instance, nearly half (47%) of all women report that they face at least one major barrier in accessing health care, with distance to health center being the most common; more than half of all people in India (55%) have no toilet facility; and 43% of children under five years of age are underweight (MoHFW India

2007). While the most recent official poverty rate is estimated at 22% in 2011, down from 37% in 2004 (Government of India 2013), the system of measurement is controversial, and others suggest at least 56% of the population lacks the means to meet their essential needs (Gupta et al. 2014).

Rural people, who compose 69% of the Indian population, are poorer than urbanites, with over a quarter of the rural population falling in the lowest wealth quintile, compared to just 3% of urbanites (Ministry of Home Affairs 2011a; MoHFW India 2007). Rural people have far lower access to education, sanitation, water, and health care than urbanites (Table 1).

The health status of Indians has been steadily improving. Life expectancy at birth has risen steadily from 36 years in 1951 to 66 years in 2015 (World Bank 2015). The crude death rate declined from 21 per 1,000 people in 1960 to 8 in 2013 and the crude birth rate declined from 41 per 1,000 people in 1960 to 20 in 2013 (WHO 2015b). The infant mortality rate has dropped from 120 per 1,000 live births in the 1970s to 38 in 2015 (WHO 2015b). In 1960 women had an average fertility rate of 5.9; by 2012 it was 2.5 (World Bank 2015). Maternal mortality has also declined from an early estimate of 580 maternal deaths per 100,000 live births in 1986 to 400 in 1998 to 174 in 2014 (Bhat, Navaneetham, and Rajan 1995; World Bank 2015).

Table 1: Urban–rural inequalities in India

Indicator	Urban	Rural
Education & access to information		
Women with no education or less than five years of education	41%	68%
Men with no education or less than five years of education	28%	50%
Women not regularly exposed to any media	12%	45%
Men not regularly exposed to any media	6%	25%
Water, sanitation & electricity		
Access to improved drinking water	95%	85%
Use sanitary latrine	53%	18%
Have some electricity	93%	56%
Health		
Received no antenatal care	9%	28%
Place of birth		
• Public facility	29%	14%
• Private facility	38%	14%
• Home	32%	71%
Total fertility rate	2.06	2.98
Under five mortality rate (deaths per 1000 live births)	51.7	82.0

Source: (MoHFW India 2007)

Despite these improving health indicators, India has consistently failed to meet national and international health targets, and has exhibited slower health improvements than other Asian countries including China, Sri Lanka and Thailand (MoHFW India 2007). India continues to have high rates of maternal mortality and child death from communicable disease, in addition to poor chronic disease management (Hunt 2007; UNFPA and United Nations Population Fund 2007; Vora et al. 2009; Reddy et al. 2005; Patel et al. 2011). Despite its remarkable economic development, India's rank in the human development index among 177 countries has risen by only two positions from 128 in 1999 to 126 in 2004 (MoHFW India 2007).

3.2 The health care situation in India

When seeking health care, Indians must choose between unregulated, for-profit private providers or under-resourced public clinics. Although there are some world-class public and private hospitals, the quality of services provided in both public and private facilities is often poor, particularly in rural areas. For instance, a stratified random sample of public and private health care providers in rural Madhya Pradesh found that 67% had no medical qualifications at all (Das et al. 2015). In rural Rajasthan, a study found that 41% of private providers calling themselves doctors did not have a medical degree, and almost 20% had not completed secondary school (Banerjee, Deaton, and Duflo 2004). In both studies, the treatment provided across these rural public and private health care facilities was frequently "irrational." Injections and drips were almost always administered regardless of symptoms. Diagnostic tests were performed in only 3% of visits in the Rajasthan study (Banerjee, Deaton, and Duflo 2004). Unnecessary or harmful treatment was prescribed or dispensed 42% of the time in the Madhya Pradesh study (Das et al. 2015).

Staff vacancies are a major issue in the public sector; for example, only 27% of auxiliary nurse midwife (ANM) positions and 16% of doctor positions are filled (MoHFW India 2014a). Health care worker motivation and satisfaction are often low, as is the quality of care provided, due to a range of factors including target-oriented rather than supportive supervision, insufficient training, frequent re-

assignment to new areas, resource shortages (medicines, equipment and staff), and a lack of appropriate incentives (George 2009; Iyer and Jesani 1995; Peters et al. 2010; MoHFW India 2014a). The public health system's inadequacy is made clear by the fact that even the poorest quintile of the population chose private care for 76% of their outpatient medical care and 58% of their inpatient care rather than visiting free government health centers (NSSO 2006).

Poor primary health care means vital preventative health care programs at the root of much communicable disease are insufficiently implemented, putting the poor at greatest disadvantage (Y. Balarajan, Selvaraj, and Subramanian 2011; Kumar et al. 2011; Patel et al. 2011). For example, national immunization coverage is 44% overall, but only 26% among children of mothers with less than five years education (Y. Balarajan, Selvaraj, and Subramanian 2011). The poor frequently delay accessing care, do not access it at all, or fall further into poverty or debt through spending on private care (Mishra et al. 2008; Y. Balarajan, Selvaraj, and Subramanian 2011).

Just over 4% of India's GDP is spent on health care, comparable to other developing countries such as China and Thailand. However, nearly 75% of this expenditure is out-of-pocket (Y. Balarajan, Selvaraj, and Subramanian 2011). With public sector spending on health only 1.1% of GDP (World Bank 2015), India is ranked 171 out of 175 countries in the world in government health expenditure as a percentage of GDP (Awofeso and Rammohan 2011).

Nonetheless, the public sector continues to play an important, albeit inadequate, role in providing health care to the poor, especially immunization, birth control, and antenatal care. Half of all institutional deliveries in rural areas occur in public clinics (MoHFW India 2007). The county has an extensive network of public facilities and a large cadre of public health workers. In addition to health services, the public system provides supplementary nutrition and is responsible for ensuring access to sanitation and water.

In 2005, the Indian government launched the National Rural Health Mission (NRHM), which sought to be an "architectural correction" of the rural public health care system (MoHFW India 2005a, 3). The NRHM involved a pledge to increase the GDP spent on health care from 0.9% to 2-3% between 2005 and 2012 (ibid). The key programmatic components of the NRHM were decentralization of health planning and management to local elected government bodies, creation of a national cadre of female community health workers (called accredited social health activists (ASHAs)), upgrading rural health centers, engaging communities, and integrating sanitation, hygiene, nutrition, and safe drinking water into health planning. A major mechanism to integrate these sectors, decentralize management, and increase community engagement was through the establishment of Village Health, Sanitation and Nutrition Committees (VHSNCs) in each village.

By 2012, public expenditure on health care was still only 1.04% and a new pledge was made to increase spending to 1.87% by 2017 (Planning Commission 2012). At

the end of 2015, public spending is at only 1.1% —far from the original goal of 2-3% and extremely unlikely to meet the revised goal of 1.87% (Chowdhury 2015). Despite the severe budgetary shortfalls, since its launch in 2005, the NRHM has successfully formed the largest cadre of community health workers in the world, introduced VHSNCs across the country, and to some extent initiated decentralization, rural health center upgrades, and intersectoral integration (MoHFW India 2014a).

3.3 Public service structure in rural India

VHSNCs are meant to bring together many key actors in the rural health system and coordinate intersectoral activity around nutrition and sanitation. There are a number of departments, ministries, programs, and actors relevant to understanding VHSNCs (Table 2). Here, I outline the official personnel requirements for public services; actual staffing is often far below standard.

At the village level (blue in Table 2) the VHSNC involves the ASHA community health worker, the ward member, who is an elected representative in the panchayat, and the anganwadi worker (AWW), who provides preschool and child nutrition services. VHSNC meetings are often held in the anganwadi center (AWC); in small villages, the AWC is generally the only public building. Village populations vary greatly but average about 1200 people.

Each group of four to six villages is clustered into a political unit called a gram

panchayat (green in Table 2), led by an elected leader, called the sarpanch. The ward members within the gram panchayat are to represent their village's interests to the sarpanch at political meetings called Gram Sabhas. Most gram panchayats will have a health sub center (HSC), which is supposed to be staffed by an auxiliary nurse midwife (ANM). Guidelines stipulate that the ANM opens the HSC for part of the day, and spends the remainder of her work hours traveling to the villages around the gram panchayat offering immunization, antenatal care, and health education. Gram panchayats are also to have a multi-purpose worker – male (MPW-M), who works in environmental health with a focus on vector control. One or more villages in a gram panchayat should also have a public school.

The next administrative unit is the block (orange in Table 2), composed of about 300 villages. Each block has several PHCs and one community health center (CHC). Guidelines stipulate that there should be one PHC for every six sub-centers. PHCs are supposed to have five in-patient beds, function around the clock, and be staffed by a doctor (called a medical officer (MO)) plus 14 additional health workers (MoHFW India 2012a). CHCs are supposed to function as hospitals, with 30 in-patient beds and 25 staff, including at least one surgeon, one general physician, one gynecologist and one pediatrician. CHCs are run by the Block Chief Medical Officer (BCMO), who also oversees all government health care in the block.

Districts (purple in Table 2) have a district hospital and a District Chief Medical Officer (DCMO) in charge of the whole district's government health system. District hospitals vary greatly in size from 75 to 500 beds depending on the terrain and

population of a district, but an average sized 300 bed hospital is to have 50 doctors, 200 nurses and paramedical staff, and 50 administrative staff (MoHFW India 2012b).

Table 2: Public system organization, from village to state level

State level department / ministry	**MoHFW (NRHM)** *Health*			**Dept. of WCD (ICDS)** *Nutrition*	**Dept. of Panchayat** *Local government*	**Civil Services** *Administration, tax, land rights*	**Other: PHED, DoE, PWD** *Sanitation, water, education*
	Community	*Facility*	*Staff*				
Village	ASHA	--	--	AWW AWC	Ward panch	--	--
Gram Panchayat ~5 villages	ASHA facilitator	HSC	ANM MPW-M	AWW supervisor	Sarpanch	Tehsildar Patwari	Headmaster Teacher Pump operator
Block ~300 villages	Block Community Mobilizer	CHC PHCs	BCMO MOs	Community Development Officer	Block Development Officer Pradhan	Sub-Divisional Magistrate	BEO AE
District ~3000 villages	District Community Mobilizer	District Hospital	DCMO	District Program Manager	Chief Development Officer Pramukh	District Collector	DEO EE

ASHAs and their supervisory hierarchy (facilitators, community mobilizers), ANMs, MPW-M, MOs, BCMOs and DCMOs are all functionaries of the Ministry of Health and Family Welfare. The AWWs and their hierarchy (supervisors, development officers, program managers) are within the Integrated Child Development Service (ICDS), run through the Department of Women and Child Development. ICDS, which began in the 1970s, initially focused on nutritional supplementation for children from birth to six years (MWCD India 2012). However, over the decades, ICDS has expanded to include nutritional support and health education for adolescent girls and lactating women.

The panchayat system has its own hierarchy from the village to the state level; it is to play a role in overseeing the health and nutrition systems and also work closely with the civil service hierarchy that manages taxes and land rights. Although VHSNCs are not officially mandated to coordinate with the civil services, in reality these actors (Patwari, Tehsildar, Sub-Divisional Magistrate and District Collector) are very powerful and must be consulted for infrastructure activities related to sanitation and water. Furthermore, VHSNCs are mandated to engage the local public schools, particularly to check sanitation and the quality of the mid-day meals served there, which involves working with teachers, headmasters and block and district education officers (BEOs & DEOs) within the Directorate of Education (DoE). Finally, to take up water and sanitation projects (e.g. having new wells bored or clearing waste) VHSNCs must coordinate with functionaries in the Public Works Department (PWD) and Public Health Engineering Department (PHED), such as executive engineers (EEs) and assistant engineers (AEs).

3.4 Village Health, Sanitation and Nutrition Committees in India

Following the 2005 launch of the NRHM, the Government of India approved guidelines for VHSNCs, stating that they were to play a central role in realizing the "community participation and ownership" goals of the NRHM and improving public health care accountability, availability, accessibility, and quality (MoHFW India 2006a, 2). VHSNCs are to develop and implement a village health plan, allocate a

yearly untied fund of Rs 10,000 (US $150), and monitor their local health and nutrition services. Government guidelines stipulate that the untied fund "is a resource for community action at the local level and shall only be used for community activities that involve and benefit more than one household" and is to support "nutrition, education & sanitation, environmental protection, [and] public health measures" (MoHFW India 2006a, 3). The guidelines further state that the fund can be used for any of the following activities:

- As a revolving fund from which households could draw in times of need to be returned in installments thereafter.
- For any village level public health activity like cleanliness drive, sanitation drive, school health activities, ICDS, Anganwadi level activities, household surveys etc.
- For the health care needs of a destitute women or very poor household (MoHFW India 2006a).

There have been several revisions to the membership guidelines, but VHSNCs have consistently been expected to involve at least seven members including the ASHA, ward member, AWW, member(s) of women's self-help groups (loan and savings groups), member(s) of the parent-teacher association, and representatives of local community based organizations. In addition, the ANM should be a member of the

VHSNC for the village in which she lives and at least 50% of the members should be female. When VHSNCs were formed in 2007, the ASHA program had just been launched and most villages had not yet selected and trained an ASHA. Thus ANMs and ward members were the initial joint signatories on the bank account for the VHSNC's untied fund. In 2010, the ASHA was to take over as joint signatory with the ward member. As described in Chapter 5 "Contextualizing Participation: Village Health Committees in Northern India" this transfer may have been problematic: some health system officials told VHSNC members that the untied fund for 2013, 2014, and 2015 could not be transferred to the joint ASHA and ward member accounts because ANMs who spent the untied fund in the late 2000s had not provided utilization certificates.

Since the launch of the NRHM in 2005, there have been 18 studies examining aspects of VHSNCs in different parts of the country. Fourteen of these studies generally assess VHSNC activity and four evaluate specific capacity-building interventions led by non-governmental organizations (NGOs). The 14 general studies indicate that VHSCs have begun to function in many states but that most are not yet performing in a robust manner.

Two rapid assessments from 2008—one in Orissa (Nandan et al. 2008) and one in Bihar, Jharkhand, Chhattisgarh and Orissa (PHRN 2008)—noted that many VHSNCs had been formed (except in Bihar where no VHSNCs had been formed) but were not yet able to access to their untied funds. By 2013, it was clear that VHSNCs in

Chhattisgarh were particularly well supported through a pre-existing community mobilization structure: Over 75% of villages reported having functional committees holding regular meetings and taking local health action (CSHRC 2013). A Government of India Planning Commission evaluation of the NRHM in Uttar Pradesh, Madhya Pradesh, Odisha, Assam, Jamu & Kashmir and Tamil Nadu (GoI Planning Commission 2011) found that while in Uttar Pradesh and Madhya Pradesh over 90% of the panchayat representatives interviewed knew about VHSNCs, in the other five states fewer than 8% did. Overall, around half the VHSNCs reported holding meetings and making some sort of health plan, but very few kept any records.

A study in an unnamed north western state (R. Singh and Purohit 2012) found that none of the 17 VHSNCs studied met membership guidelines, largely due to the fact that no ASHAs had been trained in most villages. Meetings were "on paper only" and no activities were taking place. Similarly, although many of the villages studied by Malviya et al. (2013) in Madhya Pradesh, by Raut et al. (2013) in Odisha and Gujarat, and by Semwal et al. (2013) in Uttarakhand had VHSNCs, meetings were irregular, trainings were insufficient (or had not yet occurred) and panchayat involvement was very limited.

Studies from the southern states of Karnataka (KSHSRC 2012) and Tamil Nadu (Ganesh et al. 2013) found that most committees had been formed and received some training, but meetings were not well attended. A study in three north eastern

states (Nongdrenkhomba et al. 2012) found that VHSNC composition adhered to guidelines but that the portion of VHSNCs holding regular meetings ranged from 36% in Meghalaya to 68% in Tripura to 84% in Manipur. VHSNCs were supplementing the untied fund with fund raising through voluntary donations, which is unique to this region and likely reflective of the highly devolved nature of political and economic processes in the north east.

The studies on the use of the untied fund examined areas of Madhya Pradesh (Dixit et al. 2008), Uttar Pradesh (C. M. Singh et al. 2009), Pune (MASUM & SATHI 2005), and Odisha and Gujarat (Raut and Sekher 2013). Many found that VHSNC members did not know about the existence of the untied fund, or knew of it but did not play a role in allocating the money. ANMs often spent the money with no input from the VHSNCs because meetings were not occurring regularly and because ANMs were told by their superiors how to spend the fund. In Odisha, ANMs struggled to access the panchayat representative to get the checks co-signed (Raut and Sekher 2013) and in Uttar Pradesh, ANMs reported that panchayat representatives demanded kickbacks (C. M. Singh et al. 2009). In Pune, the untied fund was overwhelmingly spent on items that should have been purchased through pre-existing budgets, such as weighing scales for anganwadi centers (MASUM & SATHI 2005).

The four studies on interventions to strengthen VHSNC functionality all featured NGO-led implementation of specific supports (trainings and facilitation) based on government requests. Two focused specifically on community-based monitoring

(CBM) of public services, a process conducted by VHSNCs and supported by a network of NGOs (S. Singh, Das, and Sharma 2010; Khanna and Pradhan 2013). Both studies noted that VHSNCs were non-functional or marginally functional at the beginning of the intervention and that CBM ignited vibrant community action. VHSNCs used score cards to measure public services and reported on violations of community health rights through large forums, meetings with stakeholders, and media efforts.

The other two publications reported on a capacity building intervention for VHSNCs in Gujarat state, conducted by NGOs at the request of the state government (FRHS 2010; FRHS 2011). The first study (FRHS 2010) reports on a one year training program provided for over 3500 VHSNCs. It detailed challenges faced by the implementing NGOs, including inconsistencies on government resolutions pertaining to the VHSNCs (e.g. it was not clear which people could be co-signatories for the untied fund account) and difficulties in recruiting busy health center staff for two-day training sessions. The NGOs did receive good cooperation from district and PHC health staff and were able to amend VHSNC membership to involve more active members. The second study (FRHS 2011) compared 50 VHSNCs that received training and 50 VHSNCs that did not receive training. It reports that 96% of the VHSNCs that received training organized health events in their villages, compared to 62% of the VHSNCs that did not receive training. A greater percentage of trained VHSNCs had a health plan (38% versus 16%), maintained registers (84% versus 20%), and had held at least one meeting in the previous year (72% versus 40%).

The Ministry's new VHSNC-guidelines, *Guidelines for Community Process*, were developed in light of the experiences in Gujarat as well as internal consultations with officials and civil society organizations from other states (MoHFW India 2013a). This dissertation draws on data collected during 1.5 years of research in which these *Guidelines* were implemented by an NGO, under a government contract, in a north western state.

3.5 The research area

This research took place in one highly marginalized block in northern India. We have called the block "Manujpur," a pseudonym. Naming the state, district, and block in which this study took place would enable the implementing NGO and some respondents to be identified.

The research block was located within 250 km of Delhi, in a poor rural area with a per capita income below Rs. 47,000 (US $702)[1]. Most people in the area were farmers, growing wheat, sorghum, and mustard, and many owned one or more buffalo, which provided milk for sale and family consumption. Men frequently migrated to the cities to work as drivers or on construction sites, and some whole families traveled during the planting or harvest seasons to work as migrant laborers on larger farms.

[1] All conversions use the Jan 10, 2016 rupees to US dollar exchange rate of Rs. 67 = US $1

The area was over 80% Hindu and approximately 20% Muslim. Among Hindus, approximately one third belonged to highly marginalized groups called scheduled tribes (STs) and scheduled castes (SCs), and over 40% were in somewhat marginalized groups, called 'other backwards castes' (OBCs). Child malnourishment was high, with 40% of all children stunted and 40% underweight.

Female literacy was particularly low in this region and over 50% of all women had no formal education. Total fertility averaged above three children per woman. Freedom of movement, access to finances, and decision-making autonomy were severely constrained for most women. Over half were not regularly exposed to any media, nearly 70% could not go out alone to markets, health centers, and community spaces, and nearly 70% had no role in decisions on issues such as their own health care, household purchases, and visiting relatives. The majority of men and women agreed that men can be justified in hitting and beating their wives in certain circumstances (MoHFW India 2007).

Villages averaged about 1200 people but ranged in size from fewer than 200 to above 2500. Figure 2 shows photos of typical villages. Families lived in multi-generational extended arrangements, with young women from other villages marrying in to their in-laws' household. Homes were made of mud or concrete and latrines were very uncommon. Even at local public schools and anganwadi centers, latrines were either not available or not maintained. The anganwadi centers were operating as infrequent food distribution centers, rather than daily pre-schools.

During the monsoon season, dirty water collected around washing areas and in muddy pits which at times made the rural roads nearly impassible. About half the households had electricity, although power cuts were frequent and long. Almost every household had a mobile phone. The region experienced chronic shortages of potable water because much of the water available was either saline or high in fluoride. Only deep bore-wells could access potable water. In some villages, all the wells failed to provide drinking water and people relied on water piped in from other areas and stored in tanks.

Figure 2: Photographs from typical villages in the study area

The public health system was highly under resourced. The HSCs, PHCs and even the CHC were almost always vacant and lacked personnel, medicine and equipment (Figure 3).

Figure 3: Photographs of vacant PHCs in the study area

The few ANMs working in the region traveled on foot or by bus to provide immunization and antenatal care in catchment areas that were at least double the size they were meant to cover, and thus almost never opened the HSCs. Some doctors in the region were deputed to the block's CHC from their PHCs, leaving those PHCs completely un-staffed. HSCs and PHCs lacked electricity and indoor plumbing. Patients who went to the CHC seeking care were frequently referred to the main town because even the CHC often had no staff.

CHAPTER 4. METHODS

4.1 Overview of the study

The data for this dissertation are drawn from a larger study, which took place in two Indian states, one northern and one southern. This dissertation draws from the northern state.

In 2012-13, the Government of India's National Health Systems Resource Centre (NHSRC), which is technical advisor to the Indian Ministry of Health and Family Welfare (MoHFW), was in the process of developing a support package for VHSNCs. The development of this support package came in response to research indicating that community engagement through VHSNCs was hampered by a lack of enabling institutional mechanisms and insufficient support and capacity building for VHSNCs (GoI Planning Commission 2011). The NHSRC collaborated with the Delhi-based Public Health Foundation of India (PHFI), which is a large not-for-profit research and teaching organization funded through public and private grants, to seek funding for implementation research on this VHSNC-support package. Researchers from JHSPH and the Indian research and advocacy organization SOCHARA also joined the partnership to develop the research protocol. The World Health Organization's Alliance for Health Policy and Systems Research funded the study through their Implementation Research Platform and additional financial support came through a grant from the Government of Canada's International Development Research

Centre. The NHSRC funded the implementing NGO partner, "SEEK" (a pseudonym) to run the VHSNC-strengthening program in northern India.

The study ran for two years (2014-2015), with active implementation and research for 1.5 years, and had two components: (1) the implementation of a VHSNC support package, described in section 4.2, and (2) longitudinal embedded research on the implementation process, described in section 4.3.

4.2 The VHSNC-strengthening intervention

The VHSNC strengthening intervention was implemented over a 1.5-year period by SEEK, a local NGO. The intervention took place in 50 out of the 200 villages in Manujpur block. The 50 villages were selected by SEEK to be in three geographically contiguous clusters of 16 or 17 villages each, because the intervention allotted three cluster facilitators to manage field visits.

Selection and training of facilitators: In accordance with the VHSNC support package design, SEEK hired three facilitators and a program coordinator. Additional details about the NGO facilitators are provided in chapter 7. All were trained for three days in the SEEK office by an NHSRC representative and then for one day in the NHSRC Delhi office. The first (three-day) training focused on VHSNC membership guidelines and developing a strategy to form the VHSNC in communities. Although not initially planned, the NHSRC trainer also spent some

time explaining the government health system and the NRHM to the facilitators, since they had not worked in the health sector before and did not know key concepts and terms such as ASHA, PHC, and BCMO. The one-day training at the NHSRC focused on reading and discussing the *Guidelines for Community Processes* (MoHFW India 2013a)and the associated *Handbook for Trainers* (MoHFW India 2013b). Several facilitators expressed a desire for additional support: they felt the training was too short and did not give them enough direction about how to run the VHSNC trainings. However, they had to rely on the *Guidelines* and *Handbook* rather than additional face-to-face training.

Social mobilization & VHSNC expansion: NGO facilitators conducted social mobilization in each of the 50 intervention villages at the beginning of the project and halfway through. Mobilization exercises involved first gathering as many people as possible at a central location, such as a school or panchayat hall, then speaking to attendees about the VHSNC and the government services that should be available. The NGO facilitators explained what the VHSNC was, the activities it could take up, and member roles. Latter mobilization also involved street theater, displaying colorful posters about the VHSNC (Figure 4), and health awareness activities in which school children called out health-related slogans while marching through the village.

Figure 4: Materials for social mobilization and training

During the mobilization sessions, the NGO facilitators asked villagers to indicate their interest in joining the committee and to suggest names of others in the village who might be good additions. Everyone in the community who expressed interest was allowed to join. NGO facilitators followed up additional nominations. The facilitators prompted additional suggestions from the villagers to fulfill the guideline requirements: at least 15 members, half female, and inclusion of representatives from all caste and religious groups in each village.

VHSNC member training: After reconstituting the VHSNCs, committee members were invited to a series of training sessions in the main town, Manujpur. These trainings were conducted by the NGO project director, program coordinator and three NGO facilitators, with some additional support from other SEEK staff involved in different projects. The NGO trained nearly 300 VHSNC members in groups of 45-60, over a series of six sessions. These trainings were spread over a year to provide several refresher trainings, to train newly elected ward members after state panchayat elections, and to avoid the harvesting season when most villagers would

be unavailable. Training contents included: the importance of community participation, information on health rights, the roles and responsibilities of VHSNC members, how to undertake local health planning and monitoring, and how to allocate and account for the untied fund. In latter trainings, VHSNC members were also encouraged to share their experiences and problem solve together.

The trainings involved both didactic lecturing by SEEK staff and discussion based activities. For example, the first training began with SEEK staff standing at the front of the room, while VHSNC members sat on the ground. The SEEK staff used colored posters (Figure 4) to explain the NRHM to participants and to explain key aspects of village-level health, nutrition, and sanitation. They then conducted an activity where participants worked in small groups to draw an image of a healthy person and then presented their picture to the larger group. These presentations engaged participants in conversation about what health means to them, and what factors make people healthy and unhealthy.

Support for monthly VHSNC meetings: After VHSNC expansion and the first training session, NGO facilitators began convening and supporting monthly village VHSNC meetings. Dates and times for monthly VHSNC meetings were set by VHSNCs in coordination with their SEEK facilitator to ensure the facilitator could attend. Since there were 16-17 VHSNCs for each facilitator, the facilitators supported one or two meetings most working days. In the days leading up to each VHSNC meeting, the facilitator would try to phone members. Sometimes they would also drop in to a

village to remind key VHSNC members in person. For each meeting, the NGO facilitator would walk around to the homes of members, calling them for the meeting. The facilitator would then convene the meeting by going over the minutes from the previous meeting, initiating discussions on health issues, and helping the group strategize about how to solve local issues. As the project period went on, the facilitators encouraged the ASHAs to take a greater role in convening meetings. They also asked literate members to take minutes. During later training sessions and at VHSNC meetings, SEEK staff emphasized that the intervention was going to end soon and that VHSNC members would have to continue without them. However, even at the end of the intervention, VHSNC members still relied heavily on the facilitator to gather people and generally run the meetings.

Cluster-level VHSNC meetings: SEEK convened cluster level meetings approximately every three months. Members from each of the 16-17 VHSNCs in a cluster were invited to gather in a central location and block level health system staff (ASHA supervisors and the BCMO) were invited as guest attendees. These cluster meetings allowed VHSNC members to share their experiences with other VHSNCs, learn strategies and struggles in other villages, and work together to address problems affecting all of them.

Support for VHSNC activities: Whenever possible, the NGO facilitators would try to support VHSNC activities beyond the VHSNC and cluster meetings. Generally, the most they could do was help deliver petitions written by VHSNCs to various

government offices and occasionally follow up in person or by telephone with administrative officials about actions requested by VHSNCs.

4.3 Study design

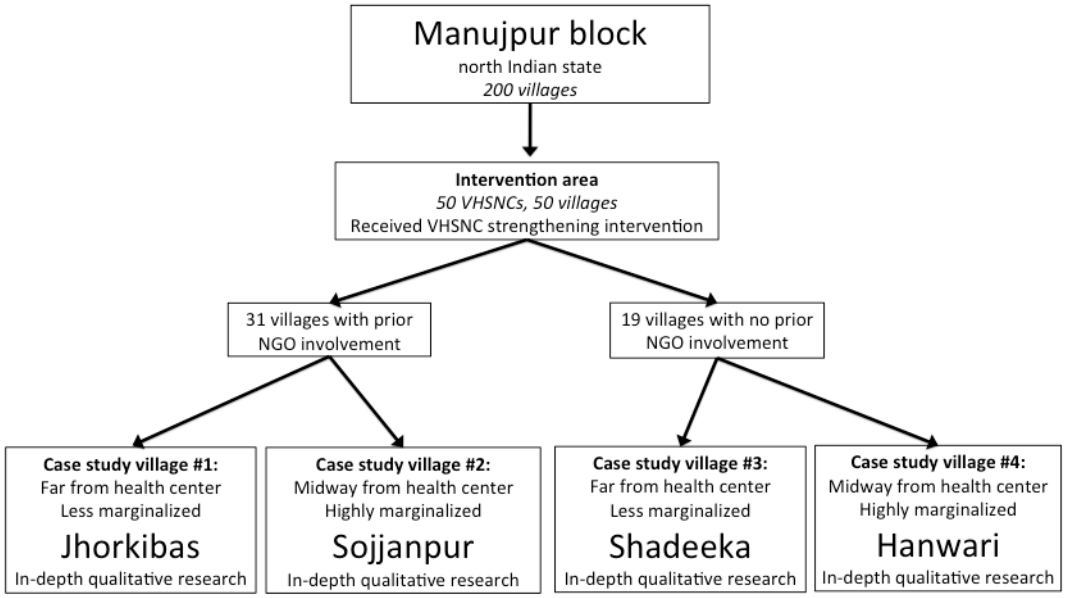
4.3.1 Site selection

This in-depth qualitative study took place over the course of 1.5 years in 2014-2015, concurrent with the intervention. The study sought to understand the relationship between the context, mechanisms, and outcomes of the intervention to inform scale up. To this end, the research team (described in detail in section 4.3.3), focused our qualitative research on a sub-set of four villages, which we called case study sites. Case study enables deep exploration of contemporary phenomenon within a real life context, where the researcher has little control over events (Yin 2009). Case studies engage a wide range of research methods, such as observation, interviews, focus group discussions, and document review, to access as many perspectives and sources of information as possible for rich and detailed understanding (*ibid*).

Selecting our case study sites was guided by the principle of purposeful sampling (Patton 1990) to ensure that we captured the experience of both typical and more marginalized villages as determined by geographic remoteness and social group (Figure 5). We also sought two villages from the 31 villages where SEEK had worked

before and two villages from the 19 villages where SEEK had not previously worked, to explore the possibility that prior engagement may have affected the intervention.

Figure 5: Research site selection



We chose two villages that were quite far (about 16 kilometers) from the town and closest quasi-functional health facility (the Community Health Center in Manujpur) and two that were mid-way (about eight kilometers), since we wanted to study VHSNC functionality in villages with low and typical geographic remoteness and proximity to health care. We also sought two villages that were more socially marginalized (composed of a larger than average proportion of scheduled caste, scheduled tribe and Muslim people) and two that were more typically mixed.

4.3.2 Respondents and data collection

We developed separate in-depth interview (IDI) and focus group discussion (FGD) guides for VHSNC members, non-VHSNC community members, health system functionaries, and NGO staff (sample guides are in annexure 1). Our sampling for VHSNC members was purposive, to include VHSNC members who participated actively and those who dropped out or attended meetings very irregularly. We were able to interview all engaged VHSNC members in all the villages, because the number of active members remained fairly low (fewer than eight people). We also returned to some key respondents for additional interviews, discussed below. For non-VHSNC members, we sought to identify respondents with different perspectives on the VHSNC, including people who refused to join or dropped out and non-members who were influential in the village or had a recent salient experience with health, sanitation, or nutrition. We engaged in exhaustive sampling for non-village stakeholders by interviewing all NGO staff working on the VHSNC-strengthening initiative and all block-level health system functionaries who we were able to reach (ANMs, ASHA supervisors, and the BCMO).

We conducted 74 in-depth interviews (Table 3). Interviews sought to elicit perspectives and stories related to: village context (anganwadi center, sanitation, health care, community relationships, prior collective action), knowledge and opinions about the VHSNC, personal experiences with VHSNC involvement, benefits and challenges associated with membership, information on other VHSNC members

(e.g., relationships between members, reasons some are more engaged than others), and information on VHSNC formation, training, meetings, and activities.

Table 3: Number of in-depth interviews and respondents by classification and gender

Respondent classification	# interviews (# respondents)		
	Male	Female	Total
VHSNC			
• General community	21 (13)	11 (8)	32 (21)
• ASHA	0	8 (5)	8 (5)
• Anganwadi staff	0	12 (9)	12 (9)
• Ward member	3	2	5
Total interviews with VHSNC members	*24 (16)*	*33 (24)*	*57 (40)*
Non-VHSNC			
• General community	4	1	5
• ANM	0	3	3
• ASHA supervisor	1	1	2
• Block Chief Medical Officer	1	0	1
• NGO staff	3 (2)	3	6 (5)
Total interviews with non-VHSNC members	*9 (8)*	*8*	*17 (16)*
Total interviews	***33 (24)***	***41 (32)***	***74 (56)***

Ten respondents were interviewed twice over the research period and four were interviewed three times. The remaining 42 respondents were each interviewed once. We chose to return to respondents for a second or third interview for three main reasons: (1) we felt an earlier interview lacked depth because the respondent was not comfortable (generally because of time constraints) or because other people joined the interview so the interviewer ended it early; (2) the respondent was involved in any specific activity or event after the first interview, which we wanted to learn more about through a second interview; and (3) a respondent was

particularly unique and insightful and we wanted to understand their evolving perspectives.

We conducted 18 focus group discussions (Table 4) to explore social norms (for example on gender relations and social cohesion) and areas of agreement or dissent on key research topics (for example on the VHSNC's prospects, why some people participate and others do not, and what actions are required to improve health, sanitation and nutrition). While the domains for focus group discussions were similar to those for in-depth interviews, the questions focused on exploring how groups of people discussed these issues, using facilitation skills such as "I'm hearing a lot of people agree with [statement]. Would you say this is common to everyone? Who might disagree?" We conducted more focus group discussions with women than with men because male perspectives dominated in public events that we observed, including in VHSNC meetings. Some focus group discussions included VHSNC members and non-VHSNC members because it was socially unacceptable to ask people to leave. Moreover, in many cases VHSNC membership was fluid, with people dropping out, joining, or even not knowing that they were listed as members.

Table 4: Focus group discussions by respondent classification and gender

Respondent type	# discussions		
	Male	Female	Total
VHSNC members	4	8	12
General community, includes some VHSNC members	3	3	6
Total focus group discussions	***7***	***11***	***18***

We observed 54 VHSNC related activities (Table 5), to better understand the context and dynamics of the committees. The observations sought to understand what topics were discussed and how, as well as amenities (equipment, cleanliness, toilets, water) and human organization (Who attends? Who is missing? Who talks? Who listens? How are people segregated? Who sits? Who stands?).

Table 5: Observations by activities

Activities observed	N
Selection of NGO facilitators	1
Training of NGO facilitators	2
NGO meetings, planning sessions, and activities	9
Community mobilization & VHSNC expansion	6
VHSNC member training	8
VHSNC meetings	15
Cluster meetings	9
General observation in communities & health centers	4
Total observations	***54***

We also collected a number of documents to gain additional perspectives on the VHSNC processes, especially to understand SEEK's formal outputs. These documents included:

- Letters from the SEEK project head to NHSRC detailing early progress and challenges
- Newspaper clippings of the advertisement for facilitator recruitment
- Photographs of the community mobilization materials, which were a series of about 15 colourful posters developed from the NHSRC's *Guidelines for Community Processes*, and included the following topics:

who the VHSNC members are; health issues in rural areas; functions of the VHSNC; functions of the anganwadi; role of ASHA

- Colourful pamphlet on VHSNC functioning, role, and membership, which was distributed to all VHSNC members
- Photographs of several letters written by VHSNCs to various government offices asking for service improvements
- Newspaper coverage of a village's efforts to improve their access to water
- SEEK's monthly progress reports
- Photocopies of minutes and attendance registers for all VHSNC meetings in the intervention area
- SEEK's final project report

4.3.3 Researchers

The data were collected by a three person team: a male research assistant (Gupteswar Patel), female research associate[2] (Shinjini Mondal), and female research coordinator (me, Kerry Scott). Gupteswar is from the state of Odisha and lived in Manujpur during the research period. Shinjini is based in Delhi, where she was born and raised. I am Canadian, based in Bangalore. Both Shinjini and I visited Manujpur frequently. All three of us had master's degrees in public health. The team had a week long orientation and training in Delhi, which I guided.

[2] Associates have more research experience and take on greater responsibility for achieving project goals than assistants; both are overseen by the research coordinator

This team debriefed after most interviews, focus group discussions, and observation events, either in person or by phone. During these debriefs, we discussed logistic challenges, such as how to ensure privacy, how to probe more effectively, the best times and places for data collection, and how to plan focus group discussions so that invited participants were able to attend but additional people were discouraged from attending. We also discussed emerging findings on our topics of interest, surprising elements, strategies to explore additional themes, and sampling (i.e. which respondents to approach next). For example, during a focus group discussion with female VHSNC members in one case study village, the group spoke of the VHSNC as non functional. However an earlier focus group discussion with men indicated that the VHSNC was taking up a number of activities. We discussed these alternative perspectives and examined our observation notes from the VHSNC meetings. We decided to try to reconcile the different experiences of VHSNC participation reported by women and men with additional focus group discussions later in the research period.

4.3.4 Reflections on data collection

Gender dynamics during data collection: Despite a social prohibition which discouraged women from speaking to men in their communities, women were able to speak openly with the male researcher (Gupteswar). However women could not be indoors alone with him. To avoid having a male family member seated nearby throughout the interview, Gupteswar conducted the interviews in clear view of

several people, such as under a tree or in an open courtyard, but far enough away from others so as to assure privacy. If men dropped by during focus group discussions with women, the women would not speak. We had to find polite and socially acceptable ways to ask the men to leave. One strategy that worked was to have the male researcher (Gupteswar) take the men to another area for an informal conversation, while Shinjini, a female researcher, continued the focus group discussion. As respondents became familiar with the researchers, this type of curiosity and interest in participating reduced significantly.

Seasonality: Seasonal events, particularly harvesting, labor migration, and festivals, played a major role in community life and made many people unavailable for interviews, focus groups and VHSNC activities for long periods of time. The research assistant was occasionally frustrated by frequent no-shows for interviews but during our meetings we developed flexible data collection timelines. We also reflected that it was a positive indicator that respondents were comfortable enough with the researcher to prioritize their more pressing engagements. State and panchayat elections occurred during the data collection period. The government imposes a code of conduct (*achaar sanhita*) upon announcing the election schedule, which meant government offices suspended activities and group meetings had to receive advance permission from police (Election Commission of India 2013). *Achaar sanhita* is enacted to avert communal (religious) clashes and corruption during election time. Our research team considered the period leading up to elections to be highly sensitive, when, Shinjini explained "small issues can lead to big

clashes." To avoid raising any concerns in the villages, we did not collect data during the several weeks of *achaar sanhita*.

Reflecting on respondent-researcher dynamics: The researchers were educated and more affluent outsiders. Community members often looked to us for solutions to local problems, as a source of ideas on what to do next, or as people who might be able to convey their problems to government officials. It was an ongoing process to build understanding among respondents that we were not able to help directly solve their problems. This process consisted of repeated discussions, initiated by respondents asking us to help them, in which we explained that we were here to learn about the VHSNC process and report our findings to others, but that we were not able to provide any resources. Our outsider identities had some advantages too. Gupteswar often reminded respondents that he was from another state and asked them to more fully explain concepts or words they used, which encouraged respondents to articulate underlying issues.

During his introduction to the villages, several male community members asked Gupteswar which caste and sub-caste he belonged to. Gupteswar's caste group (the Patels) is very large, and has different status in different states in India. So in some states Patels are Brahmins (highest caste), while in others they position slightly lower in the caste hierarchy. Gupteswar truthfully told those who questioned him that he did not know how his caste was positioned in the local caste hierarchy—but community members would likely have assumed he was from higher caste group.

He made an effort to sit with people from all castes and share food and water with everyone.

It is difficult to speculate about how Gupteswar's caste identity may have affected the research. Many people from all castes insisted there was no caste discrimination in the villages, although some higher caste people expressed negative sentiments about lower caste people to Gupteswar and some lower caste people openly spoke about discrimination. Gupteswar speculates that even if he had been from a lower caste and reported this to community members, he may not have experienced discrimination, in part because he was always considered a non-local, and thus not subject to local norms and customs (illustrated most clearly by the fact that women could speak directly to him but not to local men), and in part because his class position, as an educated person with a salaried professional job, would have modified any caste-based discrimination. Gupteswar's individual character, particularly his respect for the respondents, shown for example by his politeness, his ready understanding of their other time commitments, and how carefully and non-judgmentally he listened to them, also influenced his relationships with respondents.

Shinjini was asked twice about her caste, also at the beginning of the research period: once by a young girl and once by a woman in one of the villages. Shinjini felt that her status as an educated woman from Delhi working for a professional organization set her so far apart from the female respondents that everyone

assumed she was higher caste (which she is) and deserving of great respect. She emphasized that caste was intricately combined with the other aspects of status (education, profession, urban/rural, linguistic, and financial) and that its influence on researcher-respondent dynamics cannot be discussed in isolation.

My status as a Caucasian outsider brought additional attention to the intervention and may have generated higher expectations. Some respondents recalled VHSNC formation events as the time I came to the village and created the committees, although I had not spoken and the NGO facilitators had done all the work. Nonetheless, excitement quickly reduced and the discussions and interviews that I attended did not seem different from those I did not attend.

Many community members did not initially understand the difference between the NGO staff and the researchers. After initial orientation with help from the NGO staff, researchers made repeated efforts to orient themselves as separate from the NGO by visiting the villages without NGO accompaniment. This was easier once the research assistant got his own motorcycle. Generally these efforts were successful, although even at the end of the intervention several people still saw the researcher as another NGO staff member. Respondents were nonetheless forthcoming about negative aspects of the VHSNC. Some community members also thought the research assistant may have been supervising the NGO facilitators, since he was always watching them with a notebook. Fortunately, the community members were comfortable enough with the researcher to ask him about this, so he could explain

that he was not evaluating or supervising but instead trying to document strategies and challenges to inform scale up.

Reflections on researcher relationship with implementing NGO: We were occasionally concerned that the implementing NGO misunderstood the researchers' role. At times Gupteswar felt that the implementing NGO sought his help as an additional support staff to improve the intervention, when he wanted to remain an observer. At other times, he detected concern among NGO staff that he was evaluating them. He repeatedly explained that he was not an evaluator and instead wanted to understand challenges and limitations facing the NGO, so that future scale up could more accurately account for field realities. Sometimes the presence of the researcher may have been used as a management tool by higher level NGO staff, who, for example, reprimanded NGO facilitators after a poorly attended VHSNC training event, saying "you should beg the researcher not to report back how bad that event was." Over time, when the NGO staff realized that researcher curiosity about challenges was not linked to funding and did not bring trouble to the NGO, the NGO staff became increasingly eager to share their feedback on issues they faced and barriers to implementation.

4.3.5 Translation

We worked with a pool of six translators. All were bachelor's degree holders from English medium educational institutions, and several were master's level social scientists, including one linguist. We asked the translators to listen to the audio in Hindi and type the best possible English translation on a sentence by sentence basis, including "umhum" and other audible non-verbal components of the recording.

The translators were hired on open contracts, which enabled our team to offer transcription and translation work on a file-by-file basis, as and when we chose, and enabled the translators to accept or reject the work offered, according to their time availability. This way, we could simply stop offering work to translators with whom we did not want to continue working, and translators had the flexibility to take up work only when they were able, since many were also working elsewhere or running a household.

We worked hard to assure high quality translations. For each new translator, we explained our translation expectations and offered them an example of a high quality translation. The research associate or research assistant checked each transcript in its entirety, by listening to the audio while reading the translation. I then read the English transcript again to clarify any phrases that were unclear to my western understanding of English. We offered extensive feedback to the translators.

We asked them to resubmit any transcripts that contained errors or missed content and we rechecked these transcripts.

We had a number of challenges at the beginning. Several translators who made it through our recruitment process were later dropped because their work did not meet our standards. Common issues were: (1) translators summarizing content rather than translating on a sentence-by-sentence basis, (2) translators who lacked the English language skills to adequately express the Hindi content in English; (3) translators who were competent in English and Hindi but could not handle the regional variation of Hindi spoken in the research area; and (4) lack of attention to detail. We gave translators feedback the first time we encountered any issues but if quality did not improve we stopped offering them future work.

During coding and analysis, I frequently returned to the research assistant and research associate to check important and nuanced passages. They listened to the audio again and confirmed that the English translation adequately represented the respondent's statements or made appropriate corrections.

4.4. Data management and analysis

4.4.1 Ensuring high quality research

Qualitative social research is premised on the understanding that there are multiple realities and truths, depending on the culture, identity, and assumptions of the researcher (Creswell 1997). It is thus problematic to assess research along the lines of validity and reliability, which assume the presence of a single true interpretation of the world (validity) and the importance of stable findings, regardless of who conducts the research (reliability). But if there are multiple 'true' ways to understand the world, what makes good research? Although debate continues about how the concepts of reliability and validity translate into qualitative research paradigms, there are now widely accepted principles of rigor in qualitative research, against which studies can be judged (Morse et al. 2002; Sandelowski 1986; 1993; Guba & Lincoln, 1994; Lincoln 1995). Table 6 presents key principles of quality for the research process, as summarized by Gilson et al. (2011), and outlines how this study applied them.

Table 6: Principles of quality (Gilson et al. 2011) and applications to this research

Principle	Explanation	Application
1. Prolonged engagement	More time spent with study subjects and in the study site enables unplanned interactions that may reveal subtle or rare social dynamics and experiences.	Research spread over 1.5 years. One embedded researcher, two others made repeated visits. Informal engagement, repeated interviews, repeated observations over seasons. Many initial challenges in respondent-researcher relations (e.g. respondents concerned that they cannot speak frankly about within-community friction) reduced through prolonged engagement.
2. Use of theory	Using theory to guide sample selection, data collection and analysis ensures research follows underlying logic and matches the research question.	Case selection guided by theory of relevant supports and barriers, as well as components of marginalization. Analysis linked to theories of contextual spheres affecting VHSNCs, theories of power, and community participation.

Table 6: Principles of quality (Gilson et al. 2011) and applications to this research

Principle	Explanation	Application
3. Case selection	Purposive selection to allow prior theory and initial assumptions to be tested or to examine ''average'' or unusual experience	Since the purpose of the broader study was to generate lessons for scale up, the study location was selected in a part of north India that shares many socio-economic features across the other large north Indian states. The four villages were selected for typical and more marginalized sites, guided by our interest in how both typical and more marginalized populations experienced VHSNCs.
4. Triangulation	Overall goal is not to seek consensus but understand multiple ways of seeing the data. Denzin (1978) and Patton (1999) identify four types of triangulation: Methods, sources, analyst and theory/perspective.	Triangulation by methods (FGDs, IDIs, documents, observation, informal discussions) and sources (different points of time, range of locations and range of respondents) enabled us to check the consistency of findings from different methods and explore complementary, alternative, and conflicting perspectives. Triangulation by analyst: The broader research team was engaged throughout, which exposed my interpretations to other perspectives and highlighted blind spots. Triangulation by theory/perspective: The papers present an examination of the data through a variety of lenses including programmatic, political economy, feminist and post-modern focuses. Other analysts on the team brought additional theoretical perspectives, for instance the principal investigator Kabir Sheikh brought many years of experience with health systems and policy perspectives.
5. Negative case analysis	Looking for evidence that contradicts my explanations and theory, and refining them in response to this evidence	As I was developing the findings, I questioned my interpretations and sought alternative explanations. For example, I found myself assuming that women would not be able to attend VHSNC training and that men would block women from participating in the VHSNC or deny the importance of them participating. These assumptions likely arose from my tendency to sympathize with women's struggles, my sense that men in the villages were generally unsupportive of women's rights, and women's own discussion of the limitations placed on their movement. However, when I interrogated these assumptions I found that they were incorrect: while it may have been difficult for women to attend meetings in Manujpur, female attendance was about 50%. Moreover, when SEEK held a training for newly-elected ward members, husbands of female ward members attended the training with their wives, which enabled the women to participate. Also, male VHSNC members (at lease verbally) endorsed the involvement of women in the committee.

Table 6: Principles of quality (Gilson et al. 2011) and applications to this research

Principle	Explanation	Application
6. Peer debriefing and support	Review findings with other researchers on a continuous basis to seek diverse opinion and insight.	Larger team reviewed the findings. Team members, particularly the research assistant and research associate felt the papers I developed resonated with their understanding of the data.
7. Audit trail	Keep detailed record of data collection and analysis. Provide full account of how methods and case selection evolved	Extensive memo writing to document thought process, purposive sampling rationale, etc. All data filed carefully to enable return to the original source (i.e. audio/observation note) in case of questions. Coded outputs show which text segments were classified under which code. Extended findings report available to those interested in understanding the entire breadth of the data.

4.4.2 Ethics

The study received ethical approval from PHFI's Institutional Ethics Committee (TRC-IEC-178/13) and the World Health Organization's Research Ethics Review Committee (RPC581). The Institutional Review Board of the Johns Hopkins Bloomberg School of Public Health determined that it did not need to review the study in light of prior approval from the PHFI and WHO ethics committees.

The decision not to name the north Indian state where this study took place was made in order to ensure anonymity of the NGO-staff respondents, the block chief medical officer (BCMO) and other block-level health system functionaries. The NGO worked in only a few locations, and in only one state. It thus would be possible to identify the NGO and likely the block if the state was named.

CHAPTER 5. CONTEXTUALIZING PARTICIPATION: VILLAGE HEALTH COMMITTEES IN NORTHERN INDIA

5.1 Abstract

Background: Health committees are a popular strategy for facilitating community participation in health, particularly in low and middle income countries. Their potential effects are mediated by a number of factors including the contextual environment in which they function. George et al. (2015) developed a framework that identifies four porous and interconnected spheres of context most relevant to health committees: community, health facility, administration and societal. We apply this framework to a contextual analysis of an intervention to strengthen Village Health, Sanitation and Nutrition Committees (VHSNCs) in rural north India, examining features in each sphere that influenced VHSNC outcomes.

Methods: Over the course of 1.5 years, 50 marginalized villages in a north Indian state received a government-designed VHSNC support package, which included social mobilization, expanding VHSNC membership, training, and ongoing facilitation for committee meetings and activities. Qualitative research through interviews (n=74), focus groups (n=18) and observation (n=54) explored the contextual features that facilitated or hindered intensified community engagement

by VHSNCs. Thematic content analysis enabled the identification and grouping of themes, and detailed exploration of sub-themes.

Results: Within the community contextual sphere, VHSNCs were challenged by social hierarchies that prevented people from speaking out about local issues, particularly gender norms that curtailed women's active participation. In addition, communities exhibited deep mistrust of government institutions, which made people wary of investing in the VHSNC. Within the health facility sphere, VHSNCs were hindered by the severely under-resourced health system and the need for increased support to enable frontline health workers to facilitate VHSNC functionality.

Within the administration contextual sphere, we found that community members prioritized improved water access above all else, but VHSNCs could not engage in the large-scale infrastructure projects required to address this problem. Beyond this issue, block level health system functionaries often lacked the power to respond to other VHSNC requests, especially for hiring nurses and doctors to fill vacancies. VHSNCs were then left unsure of how to advocate for much-needed change. The chain of responsibility for aspects of VHSNC administration was opaque, which, for example, made it difficult for VHSNCs to identify why their Rs. 10,000 (US $150) yearly fund was not released throughout the 1.5-year period. Furthermore, despite VHSNCs' intersectoral nature, working on health, sanitation, and nutrition, they struggled to involve diverse government services and only received official support from the Ministry of Health and Family Welfare.

In the societal sphere, although decentralization reforms empowered the locally elected system of government (called the panchayat), many VHSNCs were still unable to engage the powerful elected representative (called the *sarpanch*), and instead worked with the lowest level elected representative (called *ward panch*), who they considered ineffective. The prevalence of market solutions to fill gaps in government service provision (such as private health care, schools, and wells) reduced the willingness of some people to work on VHSNC activities, since they were already paying for private services.

Conclusions: The VHSNC-support intervention succeeded in its core elements of expanding committee membership through a participatory process, training VHSNC members, facilitating monthly meetings, and helping VHSNCs take some actions to improve local health. However contextual barriers, particularly at the health facility, administration, and societal levels proved formidable and severely limited VHSNC capacity to succeed in improving local health services. Contextual features that would provide essential support for VHSNCs include: basic staff and resources for government health services; clear pathways of accountability for public services so that VHSNC members would know where to go to seek change; improved intersectoral coordination at higher levels of government; and extended decentralization of power.

Keywords: health committee; context; health facility; health administration; decentralization; gender; India; community

Key messages

- The capacity of village health committees to function as institutions for community participation in health is highly contingent upon an enabling context
- In rural north India, contextual features at the community, health facility, administration, and societal level were often at odds with health committee functionality
- Contextual barriers at the community level were not insurmountable, but barriers at the health facility, administration, and societal level severely constrained VHSNC functionality and success
- This paper identifies features of an enabling context for health committees

5.2 Background

5.2.1 Health committees in context

Health committees are increasingly identified as a mechanism for facilitating community participation in health, particularly in low and middle income countries (LMICs) (McCoy, Hall, and Ridge 2011). These committees have been theorized to contribute to a range of health systems goals, including improved accountability in peripheral health services, participatory health planning, expanded community support for health workers, local management of facilities, improved reach of health

services and health messages, and local resource mobilization to bolster resource-strapped health systems (Goodman et al. 2011; Molyneux et al. 2012; Shukla, Scott, and Kakde 2011; Mortier and Arpagaus 2005; Bishai, Niessen, and Shrestha 2002; Iwami and Petchey 2002a; McCoy, Hall, and Ridge 2011). Highly functional health committees in Uganda are documented to have brought about beneficial health outcomes, including reductions in infant mortality by 33% (90% confidence interval: 8%-64%)(Bjorkman and Svensson 2009).

Health committees vary greatly in membership, support, resources, and mandate; they also operate in different health system, social, cultural, and political contexts (McCoy, Hall, and Ridge 2011). This diversity makes health committees highly variable in terms of functionality and effectiveness, with positive outcomes by no means guaranteed. Committees have been hampered by a lack of formal mandate and authority (Glattstein-Young and London 2010), at times linked to broader bureaucratic resistance to decentralization (Israr and Islam 2006; Zakus and Lysack 1998; Mosquera et al. 2001). The functionality of the broader health system has a major effect on how health committees operate; in weak health systems, health staff cannot respond to committee demands and health committees can develop strained relations with health center staff (Goodman et al. 2011). Unjust social structures are often replicated in health committees, with some failing to include women (Foley 2001) or other marginalized social groups (Loewenson 2000b; Bishai, Niessen, and Shrestha 2002).

The fields of health behavior and social psychology have long grappled with the question of how context, particularly issues of socio-economic inequality and injustice, is mediated at the community and individual levels to determine health and wellbeing (Bandura 2001; Rappaport 1987; Cornish 2004). In the field of health behavior change, Tawil, Verster and O'Reilly (1995) introduced the concept of enabling environments, highlighting the need to alter the economic and political contexts in which people live to facilitate healthy behavior—rather than merely seeking individual behavior change. This concept can be extended to health interventions, by asking what environments enable interventions such as health committees to function effectively. In health policy analysis, consideration of context, rather than simply policy content, illuminates the "messiness" and political nature of policy design, adoption and implementation (Walt and Gilson 1994; Collins, Green, and Hunter 1999). This "messiness" refers to the fact that policies are not simply rational solutions to health systems problems, but instead involve inconsistencies and contradictions, as well as implicit and explicit components, which arise from broader structures and processes that do not always align with the purpose of health policy (i.e. improving the health of populations) (Collins, Green, & Hunter, 1999).

Attention to the ways in which context mediates the outcomes of health interventions enables better understanding of how effects are produced. For example, contextual analysis is being increasingly applied in the field of social accountability (Flores, Guerzovich, and Rosenzweig 2014) and to explain why

policies have differing effects in different locations. Belaid and Ridde's (2014) contextual analysis of the implementation of childbirth subsidies in public health facilities in Burkina Faso found that facility births immediately increased in health centers where health workers conducted outreach, users had positive perceptions of quality of care, and female staff arrived, while the policy had no effect in facilities that lacked these attributes (Belaid and Ridde 2014). Contextual analysis can help improve specific interventions, either by identifying aspects of the environment that can be altered to better support the intervention, or aspects of the intervention that can be adjusted to better suit the context. In addition, greater understanding of context, and how context interacts with an intervention, can generate transferrable knowledge to inform interventions elsewhere. However, this contextual knowledge must always be reinterpreted and adapted to other settings rather than applied in a formulaic or linear way to intervention design and implementation (Rifkin 1996). Growing understanding of the need for contextual adaptation is reflected in the movement away from "best practice" reforms to those that "best-fit" specific contexts (Bukenya and King 2012).

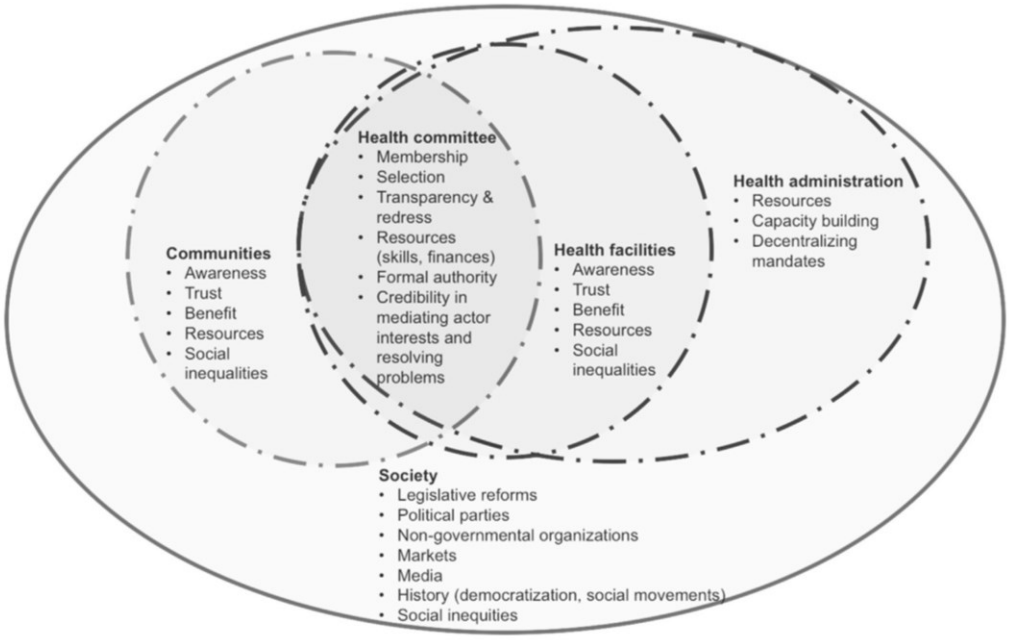
5.2.2 Conceptual framework

In a recent review of contextual factors that influence health committees, George *et al*. (2015) emphasized the dynamic relationships and linkages between features of context and the phenomena of interest: the health committee both influences and is influenced by its context. This paper applies the framework to a case study of an

intervention to strengthen the functionality of village health, sanitation and nutrition committees (VHSNCs) in rural north India.

We organize our examination of context using George *et al*.'s framework, which seeks to focus attention on the features most relevant to the functionality and effectiveness of health committees in LMICs (Figure 6). The framework identified four interconnected spheres: community, health facility, health administration and society. For each sphere, we sought to determine aspects that enabled and hindered VHSNC functionality and effectiveness as an institution for meaningful community participation in health.

Figure 6. George et al.'s conceptual framework on contextual spheres influencing health committees



5.3 Methods

5.3.1 Study setting

VHSNC policy in India: VHSNCs are envisioned by the Indian Ministry of Health and Family Welfare (MoHFW) as a key institution to support the "community participation and ownership" goals of the National Rural Health Mission (NRHM) (MoHFW India 2005a, 2). These committees began being formed at the village level across India in the mid-2000s. They are mandated to bring together many key actors in the rural health system including: community health workers (called Accredited Social Health Activists or ASHAs), anganwadi workers (AWWs), Auxiliary Nurse Midwives (ANMs), members of the local elected government, and other interested citizens. Anganwadi workers are the frontline functionaries in the Integrated Child Development Scheme (ICDS) under the Department of Women and Child Development, which seeks to provide supplementary nutrition and child development services through designated buildings (anganwadi centers) in each village.

VHSNCs are to convene monthly meetings, conduct local level health planning, and monitor the anganwadi system and government health services. They are also to receive a yearly "untied fund" of Rs. 10,000 (US $150) to spend on local public health needs as they see fit.

VHSNC ground realities: Officially, over 500,000 VHSNCs have been formed since their inception in the mid-2000s (MoHFW India 2013a). Many committees, however, have been found to be largely inactive. VHSNC members have been found to know little or nothing about their roles and responsibilities, lack training and guidance on monitoring and preparing village health plans, and received insufficient support from higher level health system functionaries (Malviya et al. 2013; Nandan et al. 2008; Semwal et al. 2013; R. Singh and Purohit 2012).

VHSNC strengthening intervention: New guidelines, called *Guidelines for Community Processes*, released in 2013 (MoHFW India 2013a), clarify VHSNC objectives, activities, and outcomes. They recommend that VHSNC membership be expanded from seven to 15 people, and outline the training, capacity building, and support that VHSNCs should receive. The National Health Systems Resource Center (NHSRC) (technical advisor to the MoHFW) collaborated with the Public Health Foundation of India to conduct implementation research on the small scale application of these new guidelines (discussed next) to derive lessons for scale up.

The study: For 1.5 years (2014-2015) "SEEK[3]," a small NGO, implemented the VHSNC strengthening intervention in 50 villages, while a core team of three researchers conducted an embedded, longitudinal study to understand the contexts, pathways and mechanisms that impeded or facilitated intensified community engagement by VHSNCs.

[3] We use pseudonyms for the NGO's name, the research block, all respondents, and all local locations

Study area: The intervention and research took place within "Manujpur" block, an impoverished area within 250 km from New Delhi. According to the 2011 census, the block has a population of about 300,000 and is 96% rural. A large portion of the population is especially marginalized: 18% scheduled caste (SC), 12% scheduled tribe (ST) and 20% Muslim. Literacy is 80% for men and 50% for women.

Most people in the region are farmers, growing mustard, sorghum, and wheat, and raising buffalo for milk. While some families own large irrigated plots of land, motorcycles and tractors, the majority have only small plots, no motorized vehicles and describe themselves as very poor. Many men migrate to find farm labor or jobs as drivers; in some villages whole families migrate seasonally for work.

Most villages range in size from about 500 to 2000 people, living in households of extended families, with young women from other villages marrying into their in-laws' homes. Houses are small mud or concrete one-story buildings, usually containing simple wooden beds (charpoys), a few plastic chairs, bundles of clothes and blankets, a small TV, and cooking ware, with no indoor plumbing and irregular electricity. Stagnant dirty water and piles of garbage are an issue in all the villages, and toilets are uncommon. Many villages are accessible only by poor quality roads that become almost impassable due to mud and flooding in the monsoon season.

5.3.2 Study design

The study focused on understanding how the VHSNC-strengthening intervention played out in four case study villages to enable deep understanding of the social, political and financial dynamics of VHSNC participation and action at the village level. At the outset we selected these four villages (which we call Jhorkibas, Sojjanpur, Shadeeka, and Hanwari) out of 50 villages receiving the intervention, to enable us to follow them longitudinally over the 1.5 years.

We selected villages that were more and less geographically removed from the main community health center and which had populations that were primarily composed of marginalized social groups (Muslim, SC and ST) and that were a mix of caste and religious groups (more 'other backwards caste' (OBC), a caste group considered less marginalized than SC and more marginalized than 'general' caste). Table 7, below, presents a general overview of the four case study villages.

Table 7. General overview of case study villages

Village	Jhorkibas	Sojjanpur	Shadeeka	Hanwari
Selection (remoteness & marginalization)	Far from CHC (16 km) Less marginalized	Midway from CHC (8 km) Highly marginalized	Far from CHC (17 km) Less marginalized	Midway from CHC (10 km) Highly marginalized
Caste communities	Muslim: 57% OBC: 30% SC: 13%	Muslim: 76% SC: 21% OBC: 2%	OBC: 79% SBC: 20% SC: 1%	ST: 62% SC: 19% OBC: 18% General: 1%
Literacy	54%	50%	55%	86%
Affluence	Very poor	Poor	Poor	Comparatively affluent

While we focused on these four villages, we were able to gain additional insights into the entire intervention area of 50 villages throughout our study. This was possible because the NGO staff, ANMs, ASHA supervisors, and BCMO who we interviewed reported events and experiences beyond our four case study sites. In addition, NGO activities, VHSNC trainings, and cluster level meetings that we observed included VHSNC members from across the 50 villages. We alsp conducted focus groups in several non-case study villages while exploring the area before selecting our case study sites. Furthermore, an exceptional experience was reported to us in a non-case study village within the 50 villages receiving the intervention. Accordingly, we visited this village ("Garijwara") to document the unique activities that took place there, discussed in section 5.4.4 on media.

5.3.3 Data collection

The research involved 74 in-depth interviews, 18 focus groups (Table 8), and 54 observations of key activities (Table 9). We purposively selected respondents to ensure perspectives from a wide range of stakeholders, including community members, NGO staff, ANMs, and block level health functionaries. Among community members, we spoke to people who joined the VHSNC, who were placed on the committee by virtue of their role as ASHA, AWW or ward member, and who did not join the VHSNC. Among VHSNC members, we interviewed those who participated actively, those who only attended a few VHSNC meetings and trainings, and those

who joined the committee but did not participate at all. For all selections, we sought respondents representing different gender, caste, and religious groups. Initially, the NGO facilitators helped the researchers gather focus group participants and identify respondents. After the primary data collector (GP) became acquainted with the villages, he approached respondents directly. NGO facilitators attended the first four focus group discussions but were not present during in-depth interviews or subsequent focus group discussions.

Table 8. Data overview by respondent characteristics

Respondent type	Gender		
In-depth interviews	# of interviews		
VHSNC	Male	Female	Total
• General community	21	11	32
• ASHA	0	8	8
• Anganwadi worker	0	12	12
• Ward member	3	2	5
Non-VHSNC			
• General community	4	1	5
• ANM	0	3	3
• ASHA supervisor	1	1	2
• Block Chief Medical Officer	1	0	1
• NGO staff	3	3	6
Total in depth interviews	***33***	***41***	***74***
Focus group discussion	# of focus groups		
VHSNC members	4	8	12
General community, includes some VHSNC members	3	3	6
Total focus group discussions	***7***	***11***	***18***

In-depth interviews and focus group discussions were audio recorded with the respondents' permission and were then translated from Hindi and transcribed into English. One respondent, an SC woman who joined the VHSNC, refused to be recorded, so SM took detailed notes during her interview. Another person (an

anganwadi worker) refused to be interviewed because she was extremely shy. An additional respondent (male VHSNC member) did not show up at a pre-arranged meeting time because of unanticipated work responsibilities and could not find time for re-scheduling. A doctor and ANM were not accessible for interviews because they were outside the block for several months.

Table 9. Observations by activities

Activities observed	n
Selection of NGO facilitators	1
Training of NGO facilitators	2
NGO meetings, planning sessions and activities	9
Community mobilization & expansion of VHSNC	6
VHSNC member training	8
VHSNC meetings	15
Cluster meetings	9
General observation in communities & health centers	4
Total observations	***54***

Interviews and focus groups yielded extensive information on the local context, including respondent experiences with government services (particularly the health system and anganwadi system), how communities in the village interact with one another, and earlier local collective action. As VHSNCs became active over the course of the intervention, we explored respondent experiences participating in the VHSNC, VHSNC activities and functionality, engagement with government, and other factors that were facilitating and hindering VHSNC functionality.

5.3.4 Data analysis

The themes presented in this paper, on the contextual features that influenced VHSNC functionality, are a subset of all the themes examined in a broader research study. Our analysis was guided by thematic content analysis, whereby we developed a coding frame inductively and deductively. It was first based on the theoretical interests guiding the research and later modified based on salient issues that arose from the data itself (Attride-Stirling 2001). After initial modification by two researchers (KES and SM), this coding framework was applied, supported by the qualitative software ATLAS.ti v 1.0.4, to enable us to group text segments into topics. The first author (Kerry Scott) then read and re-read the data outputs as they were presented for each code and extracted the salient, common, and significant basic themes. Basic themes were grouped into organizing themes, which are presented in the four contextual spheres from the George, *et al*. framework.

The study received ethical approval from the Public Health Foundation of India's (PHFI) Institutional Ethics Committee (TRC-IEC-178/13) and the World Health Organization's Research Ethics Review Committee (RPC581).

5.4 Findings

5.4.1 Overview of intervention

Table 10 below summarizes the intervention that SEEK applied, based on the 2013 MoHFW *Guidelines for Community Processes*.

Table 10: Summary of intervention, as implemented by SEEK

Social mobilization & VHSNC expansion	• Two rounds of social mobilization in each village • NGO facilitators provide information about the VHSNC and public health services • Recruit VHSNC members
VHSNC member training	• VHSNC members invited to six one- or two-day training sessions, spread over a year • Training contents include the importance of community participation, information on health rights, the roles and responsibilities of VHSNC members, capacity building for health planning, monitoring, using the untied fund, and documenting meetings • Trainings involve a mix of didactic teaching by NGO staff, group discussions, experience-sharing, and participatory exercises
Support for monthly VHSNC meetings	• NGO facilitators convene and support monthly village VHSNC meetings • Facilitators remind VHSNC members before the meetings, gather members on meeting day • Facilitators lead meetings, which involve reviewing minutes book from previous meeting, discussing health issues, and strategizing on how to try to solve local issues • Over course of intervention, facilitators attempt to transition convening meetings to community
Cluster-level VHSNC meetings	• Every three months, the NGO convenes cluster level meetings bringing together members from 16-17 VHSNCs • Block level health system staff invited as guest attendees
Support for VHSNC activities	• Whenever possible, the NGO facilitators seek to support VHSNC activities beyond the VHSNC and cluster meetings (e.g. by delivering petitions written by VHSNCs to government offices)

5.4.2 Overview of VHSNC functionality, activity & outcomes in study villages

The outcomes of interest were community engagement in the VHSNC (meeting attendance, membership, and VHSNC discussions) and improvements in village level health, sanitation, and nutrition (such as improved environmental health and better access to health services). Table 11 (below) summarizes these outcomes.

Table 11. VHSNC functionality, activities, and outcomes

Village	Jhorkibas	Sojjanpur	Shadeeka*	Hanwari
VHSNC meetings & attendance	11/12 meetings held, average 7.4 attendees, range 6-14	9/12 meetings held, average 8.9 attendees, range 7-12	11/12 meetings held, average 8.2 attendees, range 7-12	5/12 meetings held, average 6.8 attendees, range 4-11
% VHSNC attendance by gender	Female: 66% Male: 43%	Female: 64% Male: 37%	Female: 57% Male: 43%	Female: 56% Male: 44%
% VHSNC attendance by community v. % population	Muslim: 22% v. 57% OBC: 38% v. 30% SC: 49% v. 13%	Muslim: 43% v. 76% SC: 57% v. 21% OBC: 0% v. 2%	OBC: 91% v. 79% SBC: 5% v. 20% SC: 5% v. 1%	ST: 88% v. 62% SC: 12% v. 19% OBC: 0% v. 18% General: 0% v. 1%
VHSNC key discussion areas and activities	1) Sought improved drinking water 2) Concerned about irregular immunization/ ANM visits 2) Sought to enroll two orphans in support program 3) Checked midday meal quality 4) Tried to get medicines for ASHA, IFA tablets 5) Tried to help woman get JSY 6) Monitored AWC & school	1) Concerned about irregular immunization/ANM visits (& her poor behavior) 2) Tried to get doctor at PHC 3) Cleaned PHC building 4) Tried to get medicine in PHC	1) Sought improved drinking water 2) Sought ANM, concerned about irregular immunization 2) Tried to get ASHA trained 2) Used monitoring tool at anganwadi 3) Tried to get water container, weighing machine and stethoscope 4) Spoke to headmaster about poor teacher attendance and quality at school 5) Tested midday meal at school	1) Sought improved drinking water 2) Sought ANM, concerned about irregular immunization
Service-oriented outcomes	- Successfully enrolled orphans for monthly government financial support	- ANM removed (but not by VHSNC) - Doctor re-appointed to PHC	- Received an ANM for short period of time - Improved teacher attendance (debated)	- Nothing
VHSNC assessment by members	We don't see any advantage (women, FGD_VHC_10) What is the point when there is no solution to the problems? (male, OBC Hindu, IDI_VHC_44) The information given in the meetings helps us to think about different issues (male, VHC member, IDI_COM_06).	Yes, have seen changes. ANM is transferred… [But] now there is no new appointment also. (female, Muslim, IDI_VHC_38) We are been made aware of health related issues (male, Muslim, IDI_VHC_34)	This committee has not done anything. Once a nurse was appointed but after some days she also left. (female, FGD_VHC_05) Nobody makes an effort… Nobody cares for us, we had a budget of mere 10,000 Rs which has not come up till now. We have been trying since two months now, but nothing has happened. Whole village is saying that there are no facilities here. (male, FGD_VHC_09)	People have gained knowledge… [But] I don't see any major changes. There have not been many services, by which people can feel (male, ST Hindu, IDI_VHC_54).

* ANM attended three meetings before being transferred away. She is not counted in these calculations.

As shown in Table 11, the VHSNCs managed to hold between five and 11 meetings over the course of 12 months. Average attendance was eight people, lower than the 15 stipulated in the MoHFW's guidelines. Hanwari's VHSNC struggled the most, with many meetings cancelled because no one showed up. There was no clear trend in VHSNC meeting attendance over the 12 months, nor was there a clear pattern for the month(s) in which missed meetings occurred, but we acknowledge that we are examining a very small data set. When meetings took place, the number of people in attendance ranged from a low of four in Hanwari and six or seven in the other villages to highs around 12. Participation achieved at least 50% women and included representatives from all the caste and religious communities. We noted that there was a core group of the same VHSNC members who attended the meetings regularly in all four case study villages.

VHSNCs attempted to improve a range of areas including access to drinking water, health services (by asking the health system to provide nurses, doctors, and medicine), the village school, and the anganwadi center. Most action took the form of writing appeals to various government officials. Some VHSNCs achieved concrete improvements and many people appreciated learning about health topics and health rights. But over our 1.5-year research period, we documented extensive disappointment and frustration. Member enthusiasm levels varied over time with some positive moments, especially in Sojjanpur where the VHSNC had temporary success in getting their PHC doctor re-instated. However most appeals to the government did not receive a response during our research period, and village-level

health planning and monitoring was limited. None of the attempts to get equipment or medicine were successful during our research period. Since the untied fund never arrived in any of the 50 villages, there was no health budgeting. Overall, VHSNCs met fairly regularly, identified a wide range of issues that required improvement, and sought to address them largely by appealing to government officials. In one year, the success of the four case study VHSNCs was modest, and although VHSNC members appreciated some aspects of the intervention there was significant disappointment. While there were some enthusiastic and optimistic VHSNC members who planned to keep meeting each month, most NGO facilitators and VHSNC members were not confident that regular meetings would continue after the NGO intervention finished.

We now discuss contextual features across the four spheres (community, health facility, administration, and societal) that contributed to VHSNC functionality, activities, and outcomes.

5.4.3 Contextual sphere I: Community

- **Social hierarchies prevented people from speaking out**

Committee members were prevented from speaking openly in two principal ways. First, committee members were unable to speak openly about some village-level problems, particularly the sub-par functioning of anganwadi centers, because

politically dominant families monopolized key positions. Criticizing them risked disturbing village harmony and in some cases inviting personal harm (e.g. an SC VHSNC member in Hasanpur was concerned that speaking out would result in verbal harassment, discussed below). Second, patriarchal gender norms silenced many female VHSNC members.

The anganwadi centers in each village were operating far below standard: instead of opening every day, providing preschool services and hot meals for children, they were operating only as occasional supplementary food distribution centers, open for a few hours a week to give out packets of *panjiri*, a nutrient dense snack. The common perception among respondents was that anganwadi workers were forced to pay kickbacks to their supervisors and that they kept some of the remaining food for their own families and to feed to their buffalo. Although respondents were forthcoming about these issues in interviews, VHSNC members did not speak frankly about them in meetings and avoided monitoring the anganwadi center.

The positions of ASHA, anganwadi worker, and ward member tended to be held by people from politically influential families who could not speak out against one another. For example, in Sojjanpur the ASHA was married to the sarpanch's son and was related by marriage to the anganwadi staff. She was thus unwilling to criticize the anganwadi worker and anganwadi helper, neither of whom were performing their duties. "As we belong to the same caste and same family," she said, "I cannot point fingers at them… Whatever work they wish to do, they do it. If they don't, they

don't" (Sojjanpur, female, SC, ASHA IDI_VHC_04). In another village, Shadeeka, an elderly man explained that he and many of the other health committee members were related to the anganwadi worker's family, which made it very uncomfortable to speak out against problematic behavior:

> *Respondent*: You don't know the anganwadi. Do they ever distribute the full amount of supplementary nutrition? They do not. They save it for themselves. This is happening in the entire world. Wherever you go, whosoever you ask, they keep it for themselves.
>
> *Interviewer*: So if they keep it for themselves, then can members of the health committee do anything?
>
> *Respondent*: They feel embarrassed with each other. They cannot say anything because they are relatives… We are five-seven[4] brothers of one family and if one is doing such deeds then the others cannot say. They find it embarrassing because we are relatives. (Shadeeka, male, OBC Hindu, IDI_VHC_41)

[4] In the regional vernacular, this means five to seven

VHSNC members not related to the frontline health and nutrition workers were also constrained, since they were hesitant to speak out against dominant families. VHSNC members from lower caste or Muslim families were particularly concerned about speaking out. An SC woman in the Shadeeka VHSNC explained that in VHSNC meetings: "no one speaks because [it] would create conflict" but that her situation is particularly precarious: "That is why they don't say anything. I have only one house of my caste. I remain afraid because everyone attacks on me" (Shadeeka, female, SC, Hindu, IDI_VHC_46).

Despite these concerns, VHSNCs engaged in some local action and monitoring primarily through mediation and leadership from the NGO facilitators. Community members spoke to the facilitators outside the VHSNC meetings to highlight issues that could not be brought up openly in meetings. NGO facilitators sometimes led anganwadi center monitoring as part of the VHSNC meeting, which enabled the committee to signal to frontline service providers that lapses had been noted without any single VHSNC member speaking out. Unfortunately, without any support from upstream functionaries who oversaw the anganwadi system, combined with the relative power of the anganwadi workers' families, these monitoring exercises had very limited impact on services.

The second principal deterrent focuses on women's participation. Women struggled to participate actively in the VHSNC because patriarchal social norms prohibited them both from speaking to men in their communities and discouraged travel

outside the village. (Gendered aspects of VHSNC participation are discussed in detail in chapter 6.) Meetings generally consisted of women sitting together in silence while men spoke, and many male VHSNC members were unable to name the women on the committees: "since they remain behind the veil it is difficult to know every woman. And they do not speak much" (Shadeeka, male, SBC Hindu, IDI_VHC_26).

Several respondents told us that it was difficult for women to travel to locations beyond the village, where VHSNC trainings and cluster level meetings took place, because of gender expectations that women stay home and because of their heavy burden of domestic work. An elderly respondent stressed that "it doesn't look nice, this roaming around" (Shadeeka, female, *dai*, OBC Hindu, IDI_VHC_08).

Despite women's silence during VHSNC meetings, women defended their right to be on the committee and occupied their spaces on the VHSNC, consistently comprising the majority of meeting attendees. Women also found some avenues to be heard in the VHSNC by speaking to their NGO facilitator about issues before or after meetings and by having the most vocal female member (usually the ASHA) present an opinion from the women during meetings.

- **Mistrust of indifferent government institutions made people wary of investing in the VHSNC**

Respondents overwhelmingly experienced the government to be uncaring, unfair, and inaccessible. This sentiment was applied to 'government' generally, including the local panchayat system and the various state- and national-level departments and ministries. Community members recounted numerous failed efforts to engage with government departments, such as the Education Department, Public Works Department, and Public Distribution System (PDS). For example, residents of Shadeeka submitted a complaint about the poor quality of teaching in the public school and the fact that no facility was available to teach 10th standard. Despite assurances from the department, their complaint never resulted in any action, apparently because no one in the village would pay a bribe of Rs. 10,000 (US $150) to move the file forward. An elderly man in Hanwari who was considering becoming involved in the VHSNC listed all the government failures and questioned how this activity would result in improved service provision:

> There is no ANM in this village… there are no health services available in this village. The school is also a government school, and the students have to go to Manujpur and [major city] for better schooling… Even the water system here is not maintained by the government. Even roads are also not that good… I have seen that no leaders of any political parties come here... Then how will they come for this developmental activity? (Hanwari village, male, ST Hindu, IDI_VHC_10)

Although he did go on to join the VHSNC and send a number of requests for service improvements to the panchayat and several government departments, no political leaders took notice and after a year of effort he saw no positive outcome.

In Hanwari, at most four members attended meetings regularly. Others, who were listed as members but who attended irregularly or not at all, positioned their reluctance to participate within the context of past failed efforts to improve the village through engaging with government agencies. Community members recalled writing an application to the district collector[5] to get their ration shop's hours increased. They delivered it in a group of 15 people and the collector said the matter would be addressed. However no action took place because the contractor for the PDS center was politically connected. When we asked the male Hanwari VHSNC members why they were not actively engaging with the committee, they replied in annoyance that they had already tried to take action and that the VHSNC did not give them any additional power to make another attempt worthwhile:

> You tell us, what to do now? Shall we consult with the collector again? Nobody is listening to us because that ration dealer has some direct contact with political leaders. As we have this [VHSNC] committee, shall we try through this committee? Do we have any other power to utilize for improvement in functionality of that ration shop? (M3,

[5] A high-ranking Indian Administrative Service officer in charge of revenue collection and administration of a district in India.

Hanwari, men, FGD_VHC_06)

- **Emphasis on caste & religious unity but evidence of discord**

Respondents in all four villages emphasized unity despite differences in caste and religion. The following quotation was typical:

> The great thing here is there is peace and harmony amongst the people. Here, there are no fights based on caste, or on religion… everyone remains together, maintaining brotherhood. In one another's functions, social activities, people participate. And, however much each other's help can be done, we try and help each other out. (Jhorkibas, male, OBC Hindu, IDI_VHC_17)

Despite this initial emphasis on unity, which was common among Muslims and Hindus, and people of all castes, we observed and heard indications of separation and some discord, especially in relation to negative views of Muslim communities and discrimination towards people belonging to lower castes. Different castes and Muslims lived in separate areas of the villages and some respondents noted that they did not even enter other castes' areas. Muslim families were derided by anganwadi workers, ASHAs, and ANMs for resisting immunization and sterilization, with exaggerated claims of fertility: "even if they have 10 children they don't go for

[sterilization] operation" (Jhorkibas, female, SC Hindu, AWW, IDI_VHC_30). A male respondent in Hanwari (ST Hindu, IDI_COM_03) said that the caste communities got along well but that they do not share hookah or sit on the same cot together. Lower caste people would not enter into higher caste homes and higher caste people would not eat food served at lower caste weddings and funerals.

Discord was particularly pronounced in Shadeeka. While people in Shadeeka spoke of general camaraderie between the two main higher caste groups (Rajput and Saini), the one low caste (SC) family experienced extreme discrimination. At a focus group discussion, the higher caste anganwadi worker refused *chai* brought by a SC man. The SC woman explained that the two main caste groups "hate us" and feel the "lower caste should not progress… it's their mindset. It is from the beginning" (Shadeeka, female, SC, IDI_VHC_46). The discrimination against this family was overt; for example, men openly discussed the fact that the SC family could only collect water from one of the three water taps in the village:

> *Interviewer*: But why? Can't they take water from your taps?
>
> *Respondent 1*: No, they can't.
>
> *Respondent 2*: They will have to face the crowd.
>
> *Respondent 1*: When they will face the crowd of Rajputs and Sainis. They will not be able to withdraw water from the tap.
>
> (Shadeeka, men, FGD_VHC_09)

The SC woman had to wait until all others filled their buckets, and then ask someone to fill hers. When there was a water shortage she said the women would complain about having to fill her bucket and threaten to leave her without water saying, "Our needs are not fulfilled; how do we fulfill your needs?" (female, SC Hindu, IDI_VHC_46).

VHSNCs replicated this contradictory mix. Although camaraderie prevailed among members, particularly in Jhorkibas, Sojjanpur and Hanwari, and between the main caste groups in Shadeeka, social inequities were reenacted within VHSNC functioning. Members affirmed that the committees were representative and that there was no caste-discrimination. Some spoke of the value of inclusiveness:

> If people from every community would be in the committee then we can all be in one group. Otherwise if you will take people from a single community than we all would be divided in many groups. […] Because of this, we all can stay together and work together for our village. Nobody will think that this is because of them or that is because of them, like that. (Jhorkibas, male, FGD_VHC_08)

Attendance of committee meetings generally included representatives from each community (see Table 11). However, in the two villages with Muslim populations (Jhorkibas and Sojjanpur), Muslims were under-represented on the VHSNC.

Muslim-Hindu divisions affected VHSNC action. A Hindu VHSNC member in Sojjanpur explained that "there is less talking with each other" and blamed the Muslims for not caring about health issues: "They do not pay much attention towards all these things" (female, SC, Hindu, Sojjanpur, IDI_VHC_25). Muslims were also blamed for supporting the Sojjanpur PHC doctor, who was himself Muslim, when he refused to live in the village at the PHC.

In Shadeeka, VHSNC members actively tried to exclude the SC female member by not notifying her of meetings. She attended only three of the 11 meetings that took place during the research period and said that if the NGO stopped facilitating the meetings she would surely be cut out of the committee. When she came to meetings, she squatted beside the rug that the other VHSNC members sat upon.

Communities can thus be understood to have a deep investment in the *idea* of caste and religious harmony, even if lived experiences are more complex and fraught. Despite community divisions and social exclusions, VHSNC members generally collaborated and agreed on the key village priorities.

- **Pre-existing local institutions for collective action**

VHSNCs were introduced in village contexts shaped by many pre-existing local institutions. These earlier committees and groups inculcated a number of habits, norms, and expectations that influenced the VHSNCs. The three most commonly

discussed committees in the villages were loan groups, school management committees, and indigenous conflict management groups.

Loan groups, called self-help groups, were primarily designed to enable women to access loans and save money. Savings groups for men were also occasionally discussed. These groups were generally initiated by a representative linked to a bank or government program who would help the group open an account and organize them to receive the loan or pool their savings for rotating within-group lending, or both. While loan groups imparted some bookkeeping skills that could facilitate VHSNC functioning, they also conditioned community members to see meetings and committees as worthwhile when there was a clear individual financial benefit. Women in Shadeeka explained that "due to money people get together" (Shadeeka, women, FGD_COM_03). An NGO facilitator articulated how this expectation of financial gain hindered community willingness to engage in the VHSNCs.

> [Earlier] it was related to money: they used to deposit their savings and get a loan. So their association must have been due to money... No one had to be called for a meeting. They used to come on their own at the said time and place. In [this] project we are talking about rights and there is nothing related to money… People are taking this thing negatively and people are not able to get connected with this project.

(male, Muslim, IDI_NGO_04)

School management committees were sanctioned by the government to oversee public schools, just as VHSNCs are sanctioned by the health system to oversee public health services. They began in 2000 and received a yearly government grant that the committee could spend under the leadership of the school's headmaster. While some respondents in all four villages recalled the school management committee taking some action, many reported that the committee had achieved little, that much of the money had been stolen, that the Education Department was unresponsive, and that the school management committee had long ago stopped working. School management committees shaped the context into which VHSNCs were introduced by inculcating many of the same skills and processes required for the VHSNC. Community members met regularly, developed and executed strategies on how to spend a government-provided fund, and followed up with government servants. Some saw positive outcomes such as the construction of additional buildings at the school and improvement in student attendance and teacher performance. However the overall assessment was of disappointment, which may have increased community resistance of VHSNCs.

Indigenous male conflict management groups were described as being groups of senior and respected men from each caste and religious community who came together to make decisions around the "dos and don'ts of one's clan and its tradition and rituals" (Sojjanpur, male IDI_VHC_20) or to deal with conflicts. The groups were

convened only in extreme situations, as infrequently as once every few years. This local institution reflected the high value placed on including representatives from all communities in the village when dealing with major issues—and the low value placed on involving women. While these groups played a role as "guardians of tradition," (Sen 1999) they were most commonly framed as institutions to solve community conflicts. Several of the elderly men who would participate in these conflict management groups were nominated to the VHSNC by the community and agreed to join. Their involvement indicated community acceptance of the VHSNC, but also meant that young women's participation was particularly limited.

No one in the villages recalled any prior collective action around health. Furthermore, people tended to collaborate for specific periods of time to achieve utilitarian outcomes (such as accessing money or managing an immediate conflict). None of the earlier community institutions for collective action involved the type of volunteer-driven ongoing collective action envisioned by the VHSNC policy documents, which suggested that VHSNC members engage in village cleaning initiatives or health education campaigns.

Prior collective initiatives created a local context that in some ways supported and in other ways challenged VHSNCs. Loan and school management groups imparted some formal administrative and organizational skills to community members who went on to join the VHSNC. The female savings groups helped normalize the idea of women engaging in formal collectives outside the home, albeit women-only groups.

However, challenges are seen as follows. School management groups contributed to an expectation that collective effort is unlikely to yield meaningful results. Both loan groups and male indigenous conflict management groups focused on utilitarian functions through meetings (accessing money or managing a conflict), which may have made the VHSNC's open agenda and lack of clear pathways to change feel particularly vague and unnecessary.

5.4.4 Contextual sphere II: Health facility context

- **Severely under-resourced health facilities**

The severely under-resourced health facility context curtailed VHSNC functionality. Most directly, VHSNCs were unable to build collaborative relationships with health professionals because there were so few health professionals in the region. While MoHFW guidelines stipulate one health sub-center (HSC) staffed by a resident ANM for every five villages (MoHFW India 2006b), in reality few HSCs are operational. Many HSCs are empty concrete rooms, without electricity, water, supplies, or staff. PHCs, which are supposed to provide 24 hour services staffed by one doctor and 12 additional staff (MoHFW India 2012a), often operate for only a few hours per day with one doctor and two other staff. Some, including the PHC in Sojjanpur, had no staff or supplies for most of our research period (the doctor visited a few times towards the end of the intervention but returned to Manujpur town, explaining that

without medicine or any support staff, there was little reason for him to open the PHC in Sojjanpur). Considering the lack of services, most people—even the very poor—reported that they sought emergency medical care from the private sector.

As shown in Table 12, health services for the four case study villages were severely lacking. Two did not have ANMs assigned to cover them, none had functional health centers, and two did not have active ASHAs. Anganwadi centers had one or two female staff (an anganwadi worker and helper), but many lacked toilets, electricity, and water, and opened only occasionally to distribute supplementary nutrition (called *panjiri*), rather than daily to provide cooked meals and preschool services.

Table 12. Health facility context

Village	Jhorkibas	Sojjanpur	Shadeeka	Hanwari
HSC or PHC in village?	No	PHC in village but non-functional	HSC in village but non-functional	No
ANM	ANM visits irregularly	ANM visits irregularly (very unpopular)	Vacant (MPW* from neighboring area comes occasionally)	Vacant (ANM from neighboring area comes once a month)
ASHA	ASHA	New ASHA, not yet functioning as an ASHA	Untrained ASHA, not yet functioning as an ASHA	ASHA
Anganwadi	2 AWCs staffed by 2 AWWs Opened daily to distribute *panjiri* but no hot meals or preschool services	1 AWC staffed by AWW Opened two or three times per week to distribute *panjiri* No hot meals or preschool services	1 AWC staffed by AWW & AW Helper Opened two or three times per week to distribute *panjiri* No hot meals or preschool services	1 AWC staffed by AWW & AW Helper Usually closed and non-functional

*Multi-purpose worker, a male frontline health worker who is supposed to focus on vector control and infectious disease

ANMs were to be members of the VHSNC in the village where they resided and were to serve as "special invitees" in the other VHSNCs within their catchment (MoHFW India 2013a, 39). However, ANMs were covering double, triple, or even more than

their standard catchment area because of vacancies, making it impossible for them to visit all villages regularly.

> We have ten sub centers. Out of these only three sub centers are filled. The remaining seven are vacant. So how is work done there? So they say that *Behenji* [sister, i.e. ANM] doesn't come there. (ASHA supervisor, male, SC Hindu, IDI_HS_07)

Since the HSCs and PHCs lacked residential quarters, ANMs commuted to the villages from the city and were too busy travelling between villages to attend meetings. The ANM who covered Shadeeka for a short period of time explained: "I have to look after eight villages. All of them are about 10 to 12 kilometers from here. There is no transport available to reach these places. Because of this it is not possible always to get in contact with these villages" (Shadeeka, female, ANM, IDI_HS_03).

ASHAs were to play a central role in convening VHSNC meetings. Yet many villages had no active ASHA; out of the 50 intervention villages, the implementing NGO found that 20 had no ASHA as of February 2014. The ASHA in Sojjanpur had been selected in 2009 but by 2015 still had not received any training. No one in the community thought of her as a health resource person and she had no sense of identity or capacity through her position. The ASHA in Shadeeka had submitted her

forms in 2009 but never received any training or follow up, making it very difficult for her to serve the community in any way:

> There has been no response from them… I don't know about anything. I have not received any training … I have still not been posted, then why should I go [to speak to community members]? Then people will laugh at me. I feel shy. I can go when my duty is decided. How I can go now? I have only submitted the form. (female, ASHA, IDI_VHC_28).

The anganwadi centers had many infrastructure and environmental health issues such as garbage and stagnant water surrounding the anganwadi buildings, broken walls, leaking roofs, and a lack of supplies. One anganwadi worker explained not just the infrastructure issues, but also the lack of clarity around whose responsibility it was to improve the faculties:

> Sir, my purpose of holding a meeting [FGD] here is to show you the dirt spread around the anganwadi center. The sarpanch and other ward members don't do anything about it. The building is broken and unused. During the rainy season there is complete leakage in this center… The ICDS department provides Rs. 200 [US $3] per month as a rent, which is not sufficient... Sir, please solve my problem. The

> village community doesn't listen to me. They usually say that this doesn't fall under the panchayat… They are not providing anything like chairs, tables, *dari* [rugs] etc. … They say that the government is not providing any budget to us so how can we give anything to you… We don't even have a box to keep the records safe. Rats are eating the records…. There is a lot of dirtiness around, causing health problems. Who will send their children to this dirty and bad anganwadi center? (anganwadi worker, FGD_VHC_04)

Community members questioned the value of joining the VHSNC when there was so little being offered from the government. A male VHSNC member in Jhorkibas explained that without basic health facilities, the entire concept of a health committee seemed illogical. In meetings when they spoke about the health system's shortcomings "all people say, what is a health committee if there are no facilities?" (Jhorkibas, male, SC Hindu, IDI_VHC_44).

- **Need for sustained support for frontline health workers to facilitate VHSNC functionality**

ASHAs were in charge of maintaining the VHSNC registers and received Rs. 150 (US $2.25) for showing a signed attendance register each month. In turn, ASHA supervisors checked the VHSNC meeting registers, but did not have time to be

present for most meetings. An ASHA supervisor explained that he oversees 32 ASHAs, “And in one month, it isn’t possible to visit 32 places” (male, ASHA Supervisor, IDI_HS_07). He was already busy keeping other records about the ASHA’s work in immunization and maternal health. The ASHA supervisors had not yet been given any training about supporting the VHSNC and were not held responsible for ensuring genuine VHSNC functionality. Prior to the intervention, falsifying meeting attendance registers was a common practice that ASHA supervisors were in no position to correct.

During the NGO-led intervention to support VHSNCs, meetings did in fact occur in most of the 50 intervention villages and were generally attended by an NGO facilitator. ASHAs were thus often able to access their reimbursement legitimately. When meetings did not take place, ASHAs were discouraged from showing a falsely completed register by the NGO staff. ASHA supervisors felt that they were too overstretched to take on this role and hoped the NGO would remain involved.

5.4.5 Contextual sphere III: Administration context

- **Mismatch between VHSNC capabilities and local needs**

An urgent need for improved access to clean water was the single most pressing issue for all villages. However, VHSNCs were positioned by the MoHFW guidelines as mechanisms for addressing small, village level issues (such as cleaning, local

record keeping, local service monitoring, and health education) or following up with the health system about service gaps. The following discussion with men in Jhorkibas was typical across our research sites:

> *Respondent 1*: We don't want anything, don't need a single rupee or tea but only do something on water and give us drinking water…
>
> *Respondent 2*: Drinking water is a major problem for us.
>
> *Respondent 1*: Apart from that, we don't need anything. (men, Jhorkibas, FGD_COM_08)

VHSNCs could not engage in the large scale infrastructure projects required to address this problem, such as installing water treatment facilities, piping water from other regions, or digging new bore wells. All the solutions to the villages' water problems required investments far beyond the Rs. 10,000 (US $150) untied fund, and required inputs from the panchayat, public health engineering department, water supply department, and public works department. An NGO facilitator explained:

> Almost ninety percent of the problems are related to water supply. It is a big problem and not possible for VHC. It may

> require a budget of crore rupees [Rs. 10,000,000 = US $145,900]. VHCs cannot work on these issues. (male, Muslim, IDI_NGO_04)

Nonetheless water was discussed constantly in all four case study sites, at almost all the VHSNC meetings. VHSNC members in Jhorkibas and Hanwari appealed to their panchayat leaders to assist them, but knew these requests were highly unlikely to change anything. Some complained that the panchayat candidates did not care and just gave empty promises to fix the water issue in order to get elected. Others pointed out that solving the problem was too complex for the panchayat, and that political and financial inputs would be required from a member of parliament to bring about a solution. Overall, the VHSNC's incapacity to bring about improved water access was seen to be a major indicator of the committee's limited utility.

Women in Sojjanpur explained that to solve the problem "the water supply department can construct a big tank in the village" and that the public health engineering department needed to take up the issue—but they did not see the VHSNC as a mechanism to bring about change. They said that if there were anything they could do to solve their water problem "within five minutes 50 to 100 women will come" as "everybody is suffering because of that drinking water" (woman 1). But there was no point in discussing the water crisis anymore at VHSNC meetings "because we can't see any success" (woman 2) and "because we can't see any solution for water" (ASHA).

- **Block level health system functionaries lacked capacity to respond to VHSNC's complaints**

VHSNC members sought accountability from block level health system actors for personnel issues and clinic management. However, the health system functionaries lacked the power to address most issues. At several cluster meetings, the BCMO explained to community members that he did not have the power to hire more staff and requested that communities put pressure on politicians to solve the personnel shortages:

> Although I am the head of this CHC, some aspects, including the appointment of doctors, are in the hands of politicians. I am not authorized to appoint doctors. The only thing I can do is move doctors from one institution to another within the CHC area. We have to keep on demanding services so that politicians become aware of the problem and pressure the concerned ministries to solve those issues. (Observation note, cluster meeting, OBS_VHC_26)

He explained that the Manujpur CHC was supposed to have 11 doctors but only had one, who was actually a dentist. To manage, he re-assigned three PHC doctors in the block to the CHC, but was now being pressured by the VHSNCs to return the doctors to the village PHCs. An ASHA supervisor explained that when a problem was "up to

their level," (i.e. within the medical officer or supervisor's control) they responded, but that they could not fix problems beyond them (ASHA supervisor, IDI_HS_07)

However there was ongoing confusion about responsibility for failures. While the BCMO eventually made it clear that he could not hire new staff, it was not clear to VHSNCs whether he was responsible for other issues, such as medicine availability, ambulance services, and ANM performance. The BCMO also reprimanded the VHSNCs for not making greater efforts to address staffing issues themselves but was not clear about the mechanism through which VHSNCs were to seek political solutions to their health personnel shortages.

- **Unclear chain of responsibility for VHSNC**

While the ASHA's responsibility for VHSNC functioning at the village level was clear, responsibility for VHSNC functionality at higher levels of government was not. This apparent absence of higher-level responsibility for supporting VHSNCs emerged most starkly around the question of why no villages in the intervention area were able to access their VHSNC untied funds. Over the course of the 1.5-year research period, the VHSNCs never received their Rs. 10,000 (US $150) yearly untied fund. Despite extensive efforts made by VHSNC members and NGO staff, no one at the block or village level was able to identify specific people or positions in government who were responsible for delivering the untied fund. At various times, VHSNC members and NGO staff were told by the BCMO, ASHA supervisors, the sub-

divisional magistrate, and a district program manager that the untied fund was being held at the state level, district level, and block level. They were also told at various times that that the money was coming soon, that the money was not being released to the VHSNCs because the VHSNCs had not asked for it, and that the money was not being released because the prior expenditure from many years ago had not been accounted for with a utilization certificate.

Utilization certificates are documents submitted by those spending government funds to explain exactly what was done with the money. NGO staff speculated that the ANM spent the VHSNC's untied fund between 2007, when VHSNCs were formed, and 2010, when ASHAs were told to open new VHSNC bank accounts and replace the ANMs as joint signatory (alongside the ward member). ASHAs recalled opening these bank accounts but never receiving any money. The ASHAs explained that their supervisors told them that they had to open this bank account in order to continue receiving reimbursement for their work. Since the banks demanded an opening balance of Rs. 1000 (US $15) be deposited in the account, the ASHAs used their own money, assuming they could withdraw the Rs. 1000 once the VHSNC untied fund arrived. The ASHAs also noted that they spent additional money travelling several times to and from Manujpur to open these accounts.

The failure of the untied fund to arrive hindered VHSNC functionality for several reasons: (1) it constrained village action because of money shortages; (2) it

increased community skepticism of the VHSNC; and (3) it was seen as indicative of a lack of concern from higher levels:

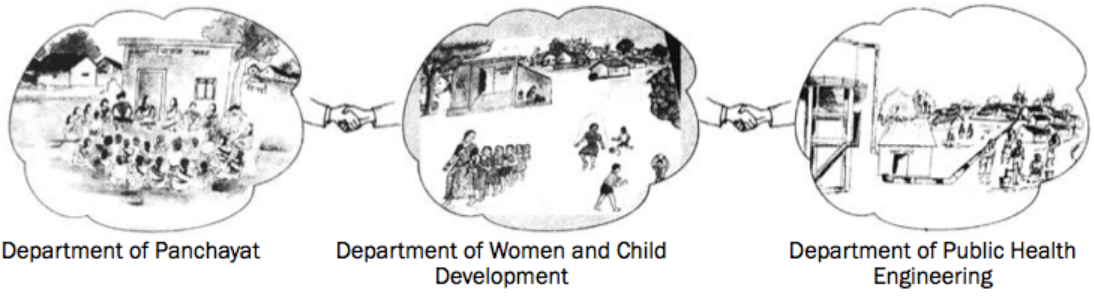
> *Man 1*: It is the same way like in farming we put so many efforts, but if no crop comes, then what is the use of doing so much work? Similarly, when no funds have come, no development has taken place, and then everyone is of the opinion that this is useless.
>
> *Man 2*: Nobody believes in the committee…
>
> *Man 1*: Yes, they always say that Rs. 10,000 fund was supposed to come for development work in village. Where is the money? Why has it not come? When we say [to our peers] that officers above us will send the fund soon, they [our peers] say it is not coming; you guys [VHSNC members] are just wasting time. (Shadeeka, men, FGD_VHC_09)

While VHSNCs and the implementing NGO attempted to draw attention to issues at the bottom, there appeared to be no one in higher levels of the health administration accountable for or invested in VHSNC success. The entire weight of VHSNC functionality was borne at the village and NGO level.

- **Fragmented government systems & unclear mandate beyond health**

VHSNCs were expected to bring together diverse actors but were only officially mandated by the MoHFW. The VHSNC guidelines state: "The mandate of the VHSNC encompasses Health, Sanitation and Nutrition as well as the Education, particularly in the context of the programs like Mid Day Meal, and most importantly Department of Woman and Child Development" (MoHFW India 2013a, 49). Figure 7 presents how the MoHFW's VHSNC guidelines depict multiple departments working hand-in-hand; the VHSNC is to coordinate.

Figure 7. Image from MoHFW's VHSNC guidelines on intersectoral convergence



Source: MoHFW (2011) p. 49.

The VHSNC is to provide "oversight and monitoring" and to "take action on social determinants of health" for the following:

- Subsidized food rations from public distribution system

- Access to work under MNREGA (employment guarantee program)
- Mid day meals
- Anganwadi services
- Safe drinking water
- Access to toilets
- Female literacy
- Women and child health

These services and programs are managed by at least seven different departments and ministries at different levels of government but the VHSNC did not receive formal support or endorsement from any of them. For example, VHSNCs struggled to involve anganwadi workers (who fall under the Ministry of Women and Child Development). Anganwadi workers were expected to play a key role on the VHSNC yet were at times forbidden by their supervisors from participating in VHSNC activities. When the NGO staff asked them to attend trainings, the anganwadi workers reported that their supervisors refused to relieve them from their duties at the anganwadi center, even though anganwadi centers were frequently shut for other reasons, and told them not to show the VHSNC their record books. NGO staff speculated that the anganwadi supervisors were uncomfortable with the VHSNC's efforts to monitor anganwadi records on the distribution of nutritional supplementation, since there was widespread corruption in the system. VHSNC efforts to work with the anganwadi system would have been bolstered by a clear

mandate from the Department of Women and Child Development, which oversees ICDS. The NGO director explained:

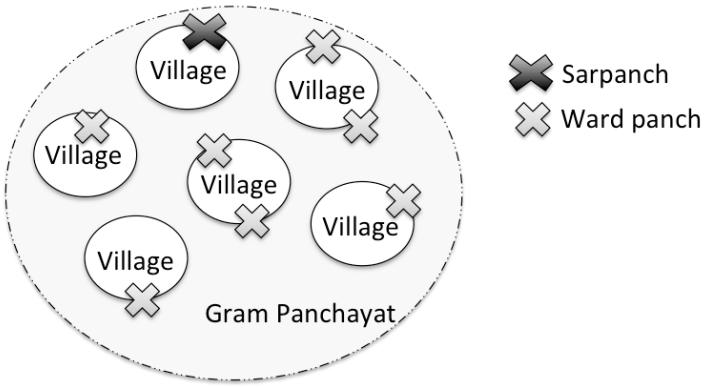
> The problem faced at this time is that the ICDS department or health department does not support [the VHSNCs]. Then what would VHNSC members do alone? They don't have power, nor do they have support. When their supporting system is ready, then progress can be seen (NGO director, female, general caste, IDI_NGO_07)

5.4.4 Contextual sphere IV: Society

- **Fractional decentralization**

Decentralization is at the heart of the Indian 73rd constitutional amendment and the National Rural Health Mission, where VHSNCs are to serve as a key mechanism for "Decentralizing Health Planning" (MoHFW India 2013a, 37). VHSNCs were designed to access formal authority through the gram panchayat system. Each gram panchayat is led by a sarpanch and composed of between four and 10 villages (Figure 8). Each village has one or more elected ward panch, depending on the village's size, who are to advocate for village needs and certify that the sarpanch is spending the budget properly. VHSNCs are supposed to automatically include the ward representative as a VHSNC member.

Figure 8. Diagram of the gram panchayat system



Source: author

However, the VHSNC members found that their linkage to the panchayat system did not enable them to mobilize funds or services to address village needs, largely because the ward panch was seen to be powerless. The sarpanch was said to funnel whatever benefits he could to his own village, such as road improvements, new wells, employment through MNREGA, and subsidies for building toilets, and to show no concern for the other villages in the gram panchayat except when seeking votes. The ward members did not have their own budgets for their villages and could only request assistance for their villages from the sarpanch. In addition, it was difficult for many VHSNCs to engage the sarpanch, several of whom outright refused to join the committee, citing other more pressing commitments.

VHSNCs thus experienced decentralization of responsibility for improving local health, sanitation, and nutrition, without the associated decentralization of financial power and authority. As an NGO facilitator explained:

> …The members of VHNC should have the authority and rights to exercise power to fix things that are out of place in the village. Still, they have not been given any authority. So we are not able to explain this or what will happen in the future. (Male, facilitator, IDI_NG0_04)

Whenever VHSNCs identified village problems they were told to take responsibility for solving them, without recognition of their limited capacity to do so. For example, VHSNCs were unable to access the panchayat system's authority and finances to improve drainage, dig wells, or clear waste, despite identifying these as pressing local needs.

- **Private sector markets**

Community members relied on the public sector as much as possible to access subsidized food and free (or at least lower cost, since unofficial payments were common) education, water, and health care. However even the poorest villagers reported that they turned to market solutions when desperate, particularly for emergency health care. Respondents explained that they sought immunization,

antenatal care, and treatment for minor illnesses from public facilities as much as possible. But for emergencies, such as injuries, high fevers, and abnormal childbirth, they went straight to the main city for private sector care.

A few wealthier community members in our research area also turned to the market for private schooling and water (by paying to dig bore wells on their property or paying to bring water from other areas by tanker). In Hanwari, the comparatively affluent village, the NGO facilitator explained the community's reluctance to participate in the VHSNC partially because of their wealthier status, suggesting that these families were more able to opt out of the public sector.

However in all the villages, including Hanwari, most respondents still saw the government as their main hope for water, schools, and sanitation since private sector solutions were expensive and piecemeal. For example, wealthier people with tractors could drive to other villages at their own expense and fetch water during droughts, but still sought a long term solution through government investment in improved water technologies and infrastructure. Desire for improved government services was unanimous, even as people expressed disappointment in the government's failure to provide them. Therefore, community members broadly agreed with the VHSNC's focus on strengthening the public sector, while also doubting whether this was possible and, in many cases, being reluctant to personally invest time in pressing the government to act.

- **Media**

Several forms of media were common across the village: many homes had televisions and men (but not women) were often seen reading the newspaper while gathered in groups; billboards and wall paintings advertised commercial products and promoted government messages. No one in the four case study villages engaged with the media to try to solve their problems. However in a non-case study village the media emerged as a strategy that could be engaged if other mechanisms for change failed. As discussed in our methods section, above, we collected data in a village, "Garijwara," that received the intervention but was not one of our four case study sites.

People in Garijwara received assistance from a local newspaper when demanding improved water. Garijwara had such poor water quality that no one would allow their daughters to marry into the village and some families were locking their homes and leaving. Women traveled 1.5 kilometers on foot to fetch water from a well that provided potable water. Although it is not possible for us to attribute the village's action directly or exclusively to the VHSNC, we noted that the village enacted a specific plan immediately after VHSNC members attended their first training. At the training, the NGO facilitator had suggested that the VHSNC file a complaint to the sub-divisional magistrate (SDM), which it did. Shortly after filing this complaint, all the men in the village staged several day-long protests in front of the SDM's office in the nearby city.

The sarpanch, a resident of Garijwara, had told the local journalists that they should highlight the village's water issue, pointing out that he frequently buys advertisements in their newspapers. Several local journalists based in Manujpur covered the protests and visited Garijwara. Women proudly told us that they spoke to the journalists and even allowed their names and photographs to be used—which was considered exceptionally bold—because, they explained, "whatever happens we need to get water to our village" (OBS_VHC_02). Several other, larger, papers also wrote about the plight of the village and the community's efforts to seek improvements. Many of the articles mentioned the VHSNC as a player, although the VHSNC did not play a featured role. One of the local papers featured Garijwara's efforts for 12 straight days, with the journalist himself even following up with the government officials. Community members in Garijwara felt that this ongoing coverage ultimately created enough pressure for the SDM to take action. Within two weeks, a piped water system was installed in Garijwara.

Although this triumph in Garijwara occurred during the first quarter of the intervention, and was discussed at many VHSNC trainings and cluster meetings, none of the other 50 villages engaged similar media processes. The particularly stark nature of Garijwara's plight and the Garijwara sarpanch's clout at the local papers may have been the unique ingredients that encouraged the media to engage with this village and not others. It should also be noted that this was the sarpanch's own village, which may have influenced these processes.

5.5 Discussion

Three major themes arise from this contextual analysis. First, on a practical level, this analysis illuminates the fact that there are many contextual challenges limiting VHSNC functionality. Our analysis further enables us to identify how an alternative, supportive, context would look. In Table 13, below, we summarize these challenges (along with some opportunities) and identify aspects of a corresponding VHSNC-enabling context.

Second, the porous nature of these contextual spheres, emphasized by George *et al*., is striking. Our classification of issues into particular spheres is suggestive, rather than definitive, since many features affect multiple spheres. For instance, challenges at the health facility, administrative, and societal levels all played out in everyday struggles facing communities. While George *et al*. noted the potential for virtuous cycles across spheres, whereby small health committee successes can invigorate members and lead to greater action and improvement at the community and health facility level, this study also revealed the power of negative cycles. For example, the failure of health administration to release the untied fund reinforced community-level skepticism and eroded VHSNC member enthusiasm. The money had a disproportionately negative effect on VHSNC functionality because it was seen to further indicate government callousness and the VHSNC's low status and power.

Table 13. Contextual challenges & opportunities and features of a VHSNC-enabling context

Contextual sphere	Contextual challenges (-) and opportunities (+) identified	Features of a VHSNC-enabling context
Community	– Social hierarchies limited VHSNC member willingness to monitor village services – Women's voice restricted by patriarchal social norms – Prior failed attempts to engage government and sense that government was uncaring caused reluctance to participate – Some division by caste and religious groups – Other local institutions for collective action emphasized collaboration for immediate gain (such as receiving loans or solving a local conflict) + Nevertheless there was general cross-community agreement on priority issues and willingness to collaborate + Other local institutions for collective action inculcated some VHSNC-relevant skills (e.g. book-keeping learned from savings groups)	• **Ongoing facilitation**: The NGO facilitators played a crucial role in enabling women to participate and express themselves and in bringing up local issues without causing village-level conflict. NGOs also worked hard to overcome community reluctance and help VHSNCs develop strategies to appeal for improved health, sanitation, and nutrition services • **Gender sensitive VHSNC support**: Further strategies can be developed to ensure women can participate in socially acceptable ways and to help men adjust to women's engagement
Health facilities	– Severely under-resourced health facility undermined almost all VHSNC efforts (e.g. there was often no health worker with whom the VHSNC could build a collaborative relationship) – Existing health care staff and officials lacked the resources and incentives to support VHSNCs	• **Adequate resources**: VHSNCs need to interact with minimally functional health services; high vacancy rates make it impossible for VHSNCs to have productive engagement with health system functionaries • **Support for supporters**: Health system functionaries need training, support, and incentives to work with VHSNCs

Table 13. Contextual challenges & opportunities and features of a VHSNC-enabling context

Contextual sphere	Contextual challenges (-) and opportunities (+) identified	Features of a VHSNC-enabling context
Administration	– Block level health system functionaries lacked capacity to respond to VHSNC complaints – Unclear chain of responsibility for VHSNC – Mismatch between VHSNC capabilities and local priorities – Fragmented government systems undermined VHSNC's intersectoral mandate	• **Clear pathways of accountability**: The hierarchy of responsibility for services must be conveyed to VHSNCs, so block level functionaries are not unfairly blamed for lapses beyond their control, and so the VHSNCs can engage with decision-makers • **Designated top down responsibility for VHSNCs**: Make VHSNC funds and support a top-down responsibility, rather than a bottom up battle • **Intersectoral coordination**: Health administration must ensure the support of all social sectors that VHSNCs are mandated to engage
Society	– Decentralization remained one level beyond most villages: the local sarpanch was considered powerful and tended to help his/her village but the other villages could only access the ward member, who was considered powerless – Many people turned to private market solutions to fill public sector gaps, making the comparatively wealthier community members less interested in working for improved public services through the VHSNC + Nevertheless, communities desired improved government services so that they would not have to spend money on private sector substitutes + A robust print media supported some grassroots action	• **Deep decentralization**: Decentralization to gram panchayats is a major victory for citizen engagement. However, power remained one step beyond the reach of most villages, concentrated with the sarpanch. VHSNCs would have greater scope if the ward member had greater access to political and financial power and if the sarpanch was responsive to the VHSNCs within his/her panchayat • **Continued public investment in the social sector:** Community participation can help guide and strengthen government health, sanitation, and nutrition programs and services, but without adequate investment the poor will need to pay for private substitutes or suffer without basic services • **Media engagement**: Develop strategies to engage media to increase VHSNC voice, enable others to learn about VHSNC actions, and generate pressure on government services to respond to VHSNC requests

The dynamic interaction between various spheres is particularly clear when examining the role of the NGO's support. NGO support worked to surmount some barriers at the community level, but was unable to address challenges in other contextual spheres. Their support proved critical to developing VHSNC capacity and functionality (as is discussed in greater detail in chapter 7, and summarized here). In the villages, NGO staff played a vital role in facilitating dialogue on the VHSNC across social hierarchies. They tried to ensure lower caste VHSNC members participated and increased women's voice on the committee. They supported ASHAs to take on greater roles as conveners. As outsiders, they were also able to introduce some anganwadi monitoring exercises without making VHSNC members vulnerable to social sanctions. The NGO enabled community members to speak to government actors in order to express community needs and to facilitate greater communication and understanding. For instance, villagers learned that the BCMO was unable—rather than unwilling—to hire additional staff to fill health facility vacancies. Overall, the NGO enabled VHSNCs to overcome many of the contextual challenges in the community sphere, but were unable to address major barriers in the other contextual spheres. These barriers eroded community interest in sustaining the VHSNC without the NGO's involvement. NGO facilitation is thus a valuable feature of a VHSNC-enabling context, but must be supported by changes at the health facility and administrative levels.

Third, as Collins et al. (1999) noted, contextual analysis reveals the "messiness" of policy development: our analysis suggests that improving the coherence of policies

and programming associated with VHSNCs will be vital for long term committee success. Specifically, the development of enabling environments (Tawil, Verster, and O'Reilly 1995) in which VHSNCs can not just increase community participation in trainings and meetings but actually bring about improvements in their health, sanitation, and nutrition, requires greater policy coherence from the national to block levels. Although the MoHFW's National Rural Health Mission policy officially promotes community participation in the public system, and although the MoHFW has developed the *Guidelines for Community Processes* (MoHFW India 2013a) to help strengthen VHSNCs, the lower level health workers and officials lack the power, resources, and incentives to support VHSNCs and respond to many community needs. Furthermore, the intersectoral nature of VHSNCs reflects an ideal that must be backed up by collaboration across government ministries and departments at the higher levels of government.

The VHSNC program, the National Rural Health Mission, and entire public service sector must be positioned within a larger context of insufficient investment in the public sector (OECD 2011). Public expenditure on social services has been consistently below minimum recommended levels to meet basic public needs (OECD 2011; Planning Commission 2012). In 2014, the central Ministry of Finance further reduced health expenditure (Menghaney 2015; J. Ghosh 2015). There appears to be a fundamental discord between the MoHFW's goals (rapidly improving health outcomes for the poor and engaging communities) (Planning Commission and HLEG 2011) and the government's health expenditure, which remains around 1% of the

GDP (Planning Commission 2012)—far below the NRHM's goal of 2-3% (MoHFW India 2005a). The severely under-resourced public sector undermined VHSNCs in many ways, for example inviting communities to participate in a system that lacked many key staff with whom to engage. While the VHSNC is envisioned to partially fill service gaps through voluntary social service (such as working to clean the village), achieving national health goals such as reduced maternal mortality and improved child nutrition requires far more than grassroots volunteerism.

5.6 Limitations and opportunities for future research

This paper presents findings from in-depth research into four case study villages, rather than all 50 villages that received the intervention. Nonetheless, the four case-study villages were fairly typical of the larger intervention area. As previously mentioned, we gained understanding of the broader area through extensive discussions with NGO facilitators who covered all 50 villages, observations of cluster meetings that involved VHSNC meetings from all 50 villages, and our examination of NGO documentation from across the villages.

Walt and Gilson (1994) argued that policy analysis has tended to focus too much on the content of reforms, rather than processes, actors, and contexts. This analysis highlights the powerful effects of contextual barriers and enabled us to develop an understanding of the key elements of a VHSNC enabling context. Future research

can now focus on identifying the processes and actors that must be engaged to move towards this enabling context.

5.7 Conclusions

This intervention focused on creating or reconstituting VHSNCs and building the capacity of members to make improvements themselves at the village-level and demand improvements in the public sector at higher levels. It succeeded in its core elements of expanding committee membership through a participatory process, training VHSNC members, facilitating monthly meetings, and helping VHSNCs take some local actions for health. However, the broader system did not change. Contextual barriers played a major role in limiting VHSNC capacity to improve local health, sanitation, and nutrition services. Technical inputs that build community capacity are necessary but not sufficient. In order for VHSNCs to be sustainable and effective mechanisms for community participation in health, they need to operate within more supportive contexts that go beyond the technical inputs.

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CHAPTER 6. SOCIAL COSTS AND OPPORTUNITIES: PARTICIPATION IN VILLAGE HEALTH COMMITTEES IN NORTHERN INDIA

6.1 Abstract

6.1.1 Background

Participatory community health programs can have broad social benefits, such as enabling marginalized groups to gain greater say in decision-making and increasing a community's sense of collective agency. However, these beneficial outcomes are by no means guaranteed, and the empowering potential of participatory processes are often limited by gender norms that curtail women's involvement and by the concentration of program control in the hands of outside actors (i.e. government officials, policymakers). This paper contributes to the literature on empowerment through participation, examining how community participation in health committees can enable and hinder the renegotiation of power relations, both within communities, and between communities and outsider stakeholders. We examine social costs and opportunities experienced by Village Health, Nutrition and Sanitation Committee (VHSNC) participants in a marginalized area of rural north India. We apply the conceptual lens of "social spaces" to explore how stakeholders engage with one another and, more broadly, how power is mediated through these committees in the construction of identity and discourse.

6.1.2 Methods

Over a 1.5-year period, we conducted 74 interviews and 18 focus group discussions with VHSNC members (including female community health workers and elected members of local government), non-VHSNC community members, NGO staff, and higher-level health system functionaries. We also observed 54 health committee activities, including trainings and meetings. After initial thematic analysis, the data were interpreted through the psychosocial theoretical lens of "social spaces" to identify how power relationships were enacted in health committees to produce social costs and opportunities.

6.1.3 Results

The intervention took place in a context where gender norms limit women's voice and control over key decisions in their lives and where male and female community members tend to describe a negative collective identity, seeing the community as unlikely to work together to solve local problems. VHSNCs created some opportunities for participants to re-negotiate power inequalities within the community, particularly around gender, through inviting gendered co-occupation of space, enabling some women to speak in front of men, and creating space for women to perform previously masculine roles. However, those who violated social norms were vulnerable to repercussions when they left the protective space of the VHSNC.

Power inequalities between the community and outside stakeholders were mediated by the health committee through an ongoing struggle around a "discourse of responsibility". Government policy, enacted by NGO staff, presented a dominant discourse portraying VHSNC members as collectively responsible for village level environmental health and for improving the delivery of much-needed public services. Some VHSNC members accepted this discourse, and in turn blamed their peers for failing to take action, re-entrenching a negative collective identity where participation was futile because no one would work for the greater good. Others rejected the discourse and argued that the VHSNC was not responsible for taking any action, explaining that government agents must intervene to help them. This counter-narrative also positioned participation in the VHSNC as futile.

6.1.4 Conclusions

Interventions to strengthen community participation must support social transformation inside communities and also enable communities to broker greater power and control in relation to broader political discourses.

6.1.5 Keywords

Village health committee; participation; agency; gender; power; social spaces; discourse; India

6.2 Introduction

Despite generating much optimism in health policy circles, village health committees often fall short of achieving the sustained and inclusive participation that is theorized to improve health outcomes and, more broadly, to empower marginalized people to gain greater control over their lives. There is little understanding of the costs and opportunities that participants assume through their engagement in these interventions. This paper explores how power inequalities play a key role in limiting community benefit from these committees and how participants actively engage with and push back against these inequalities. Our study is framed by the concept of social spaces, which illuminates the processes through which participation in health committees can create space for marginalized people to challenge inequalities and renegotiate social norms for greater empowerment. For the purposes of this study, participation is understood as the act of engaging in collective activities, such as meetings, while empowerment is understood as the attainment of increased control over decisions and resources that affect one's life and wellbeing (Rappaport 1987).

Health committees are a commonly promoted mechanism for community participation in health (McCoy, Hall, and Ridge 2011). There is some evidence that they can improve the functionality and accountability of health facilities (Iwami and Petchey 2002a; Sohani 2005; Molyneux et al. 2012; Shukla, Scott, and Kakde 2011) and increase community use of health services (Paxman et al. 2005; Loewenson,

Rusike, and Zulu 2004a). In addition to directly improving health systems and health-related behavior, participation through health committees is envisioned to play a broader emancipatory role in society as part of a dynamic and ongoing process of community empowerment, seen as a valuable end in itself (Rifkin 2014; Rifkin 1996; Zakus 1998). However, committee functionality and effectiveness is very uneven (La Forgia 1985; Mubyazi, Mushi, Kamugisha, et al. 2007; Ngulube et al. 2004), with many committees failing to achieve inclusive and sustained community engagement (Wijngaarden, Scholten, and Wijk 2012; Kasaje, Sempebwa, and Spencer 1987; Loewenson, Rusike, and Zulu 2004a).

Researchers suggest that many of the disappointing outcomes of participatory development programs can be explained by failure to manage power inequalities, both within communities and between communities and outside stakeholders such as policymakers (Rifkin 2014; Arnstein 1969; Naimoli et al. 2012). Within communities, power inequalities can prevent marginalized groups from benefiting from the participatory programs seeking to help them (Guijt and Kaul Shah 1998; Adhikari and Lovett 2006; A. Dasgupta and Beard 2007; Mosse 1994; Cornwall 2002). Some participatory programs have particularly failed to manage gender inequalities, excluding women from decision making and then expecting them to lend their time and energy to interventions that they did not design (Meinzen-Dick and Zwarteveen 1998). Power inequalities between communities and outsiders have been identified as another major issue, with elites (i.e. government policymakers, officials, program implementers) accused of using community

participation initiatives to overburden communities with unreasonable responsibilities and more broadly legitimize failures in public service provision (Rifkin 1983; Zakus and Lysack 1998; Collins 1989; Mosse 2001; Nichter 2008).

Despite the well-established importance of examining power in participation, and a robust literature documenting the exclusion of less powerful community members from health committees (La Forgia 1985; Sepehri and Pettigrew 1996; Iwami and Petchey 2002a; Ramiro et al. 2001), there remains much to be learned about how health committees contribute to renegotiating community power relations, particularly in terms of gender norms and collective agency. This paper contributes to filling this gap by examining the social costs and opportunities of participation incurred by health committee members and their communities more broadly. It examines how power inequalities are mediated through village health, sanitation, and nutrition committees (VHSNCs) in rural north India to influence social dynamics across the community, particularly in relation to gender roles and the community's conceptualization of their collective potential.

6.2.1 Conceptual framework

This paper is framed by the concept of "social spaces" (Lefebvre 1991) to map out the mechanisms through which power works within health committees to create opportunities and costs for participants. Thinking about the health committee as a social space through which power relations operate provides a fruitful lens into how

participatory programs can better create opportunities for communities to construct more health enabling social identities (Cornwall and Coelho 2006). Social spaces are interactive moments in space and time, constructed through relationships between diverse groups, which create contexts for new social representations and identities to emerge (Mead 1934; Moscovici 2000).

Producing a new space, such as a health committee, creates a momentary disruption of established rules and possibilities, into which unfamiliar rules and alternative possibilities can be ascribed (Kesby 2005b). What happens within a social space affects the broader society when participants experience incongruence between the norms within the space (such as "all voices are equal") and the norms governing interactions in regular life ("male voices are more valued"), leading them to question and challenge established ways of being and interacting (Jones and SPEECH 2001).

Inherent to the concept of social spaces is a post-modern understanding of power, as developed by social theorist Michel Foucault. Foucault proposed that power is inseparable from the development of accepted knowledge systems and that power/knowledge is continually resisted, thereby operating as a creative and constructive force (Kesby 2005b; Cornwall 2002; Foucault 1980).

Social spaces, like all realms of human interaction, are governed by discursive norms, which shape and limit what is said and done, what is say-able and do-able, and ultimately what is considered truth or knowledge (Foucault 1980; Foucault

1990). Stakeholders seek to further agendas and gain resources by establishing these discursive norms, which enable particular types of communication and action (Cornwall 2002; Lefebvre 1991). For instance, a participatory space may be constructed by elite actors to bound possibilities for discussion and community control, limiting what is at stake and what participants are entitled to know or decide (Mosse 1994). Yet, Foucault notes that power is complex and unstable; every site where power is expressed contains the potential for resistance (Foucault 1980).

Discourse is thus not only "an instrument and an effect" of power, but is also "a stumbling point of resistance and a starting point for an opposing strategy" (Foucault 1988, 100–101). Participatory spaces are frequently resisted by those with "alternative visions" about how best to "transform their possibilities" (Cornwall 2002, 9). For example, Mosse (2005) explores the ways in which targeted communities may outwardly agree to stakeholder agendas, but then exercise "quiet power" (Campbell 2014, 52) to manipulate programs to suit their own needs, displaying agency in ways not predicted by funders.

What opportunities does the health committee present for the renegotiation of accepted forms of power/knowledge for marginalized people within communities and for communities in general? What costs do participants and communities more broadly bear as a result of engaging in these "alternative spaces"? And ultimately, how can health committees better generate social opportunities for renegotiating power inequalities and minimize social costs to ensure sustainable and inclusive

social spaces that further collective empowerment? These questions guide our study.

6.2.2 Context of study

Over 500,000 VHSNCs have been officially formed across India since the mid-2000s (MoHFW India 2013a). These committees are designed to involve general community members including members of savings groups, school management groups, and youth groups, as well as auxiliary nurse midwives (ANMs), accredited social health activists (ASHAs), anganwadi workers, and elected members of the local government, called ward members. ASHAs are female community health workers, selected and trained in each village as part of the National Rural Health Mission, launched in 2005. Anganwadi workers are female nutrition and pre-school workers, who run anganwadi centers in each village. The anganwadi program is part of the Integrated Childhood Development Scheme, launched in 1975 by the Ministry of Women and Child Development. It focuses on providing pre-school care and nutritional supplementation through anganwadi centers in each village staffed by female anganwadi workers (AWWs) and helpers (AWHs). Ward members are the lowest elected member of the local governance system (called the panchayat) and are to represent their ward (i.e. village or sub-village) to the local leader (sarpanch) at political forums (gram sabhas).

The VHSNC is to convene monthly meetings, develop local health plans, take action to improve environmental health, monitor and seek improvements in public services, and allocate a yearly 'untied fund' of Rs. 10,000 (US $150). The untied fund is a grant for the VHSNC to spend on community action, as a source of revolving emergency loans, or to help destitute families meet their health care needs. Since the launch across India in the mid-2000s, committee functionality in most parts of India has remained low (R. Singh and Purohit 2012; C. M. Singh et al. 2009). Members often do not know their roles, VHSNC composition rarely adheres to guidelines, meetings are often irregular or do not take place at all, and there is often negligible community participation in budgeting, monitoring, or developing village health plans (Bajpai, Sachs, and Dholakia 2009; PHRN 2008; R. Singh and Purohit 2012).

The power dynamics of VHSNCs have been under-explored. For instance, VHSNCs are mandated to have 50% female members, and several studies have noted that most do (Nandan et al. 2008; PHRN 2008; R. Singh and Purohit 2012). But little is known about whether the women speak or have decision-making power within the committee, and more broadly how the committee may influence wider gender norms. In addition, no previous study has examined how VHSNC members feel about their mandate of improving local health, sanitation, and nutrition services.

In 2013, the Indian Ministry of Health and Family Welfare (MoHFW) developed a VHSNC support package called *Guidelines for Community Processes* (MoHFW India

2013a). This support package involved: village-level social mobilization to increase community knowledge of VHSNCs, expanding VHSNC membership from seven to 15 people, training members, and facilitating monthly village meetings and quarterly cluster meetings. Before scaling up the support package nationally, the National Health Systems Resource Center, technical advisor to the MoHFW, collaborated with the Public Health Foundation of India and other research partners to conduct in-depth implementation research at the block (i.e. sub-district) level in northern India. The findings reported here emerged from that research.

The study took place in "Manujpur"[6] block (sub-district level), a rural area with an approximate population of 300,000 people living in 200 villages and one main town (Ministry of Home Affairs 2011b). The area is located within 250 km of New Delhi and most people work as farmers and daily wage laborers. The literacy rate is 80% for men and 50% for women (Ministry of Home Affairs 2011b).

Area residents struggle to access sufficient potable water and experience many shortcomings in public services. Roads often become impassible in the rainy season, there is little public transportation, public schools are widely considered to be of low academic and physical quality (many have no water or toilets), and government health centers are severely understaffed. For example, Primary Health Centers (PHCs) are to have one Medical Officer (MO), three ANMs and 10 other support staff (MoHFW India 2012a); several PHCs in our research area had just one ANM

[6] We are using pseudonyms for the study area, implementing NGO, and all respondents to protect anonymity

assigned to them. While anganwadi centers are envisioned as pre-schools that provide daily childcare and hot meals, in our research area most were opened for only a few days per week as food distribution sites.

6.3 Methods

6.3.1 Study design

Over the course of 1.5 years (2014-2015), a local non-governmental organization (NGO), "SEEK," implemented the MoHFW's VHSNC support package in 50 of the 200 villages. From among those 50 villages, we selected four case study villages in which to carry out longitudinal qualitative research. Our research included in-depth interviews (IDIs), focus group discussions (FGDs) and observation of VHSNC activities, such as VHSNC formation, member trainings, and meetings. We chose villages that varied by remoteness and social marginalization. The two remote villages were located about 16 kilometers from the main town; the two closer villages about nine kilometers away. The two less marginalized villages were composed of a typical mix of caste and religious groups; the other two were predominantly scheduled caste (SC), scheduled tribe (ST) and/or Muslim—all extremely marginalized groups.

6.3.2 Data collection

We conducted a total of 74 in-depth interviews and 18 focus group discussions with community members and other stakeholders at the block and village level (Table 14). Fourteen respondents were interviewed multiple times over the research period to better understand evolving perspectives on the VHSNC and to follow up after specific events.

Table 14: Interviews and focus groups by respondent type and gender

In-depth interviews by group	**# interviews (# respondents)**		
	Male	Female	Total
VHSNC			
• General community	21 (13)	11 (8)	32 (21)
• ASHA	0	8 (5)	8 (5)
• Anganwadi staff	0	12 (9)	12 (9)
• Ward member	3	2	5
Total interviews with VHSNC members	*24 (16)*	*33 (24)*	*57 (40)*
Non-VHSNC			
• General community	4	1	5
• ANM	0	3	3
• ASHA supervisor	1	1	2
• Block Chief Medical Officer	1	0	1
• NGO staff	3 (2)	3	6 (5)
Total interviews with non-VHSNC members	*9 (8)*	*8*	*17 (16)*
Total in-depth interviews	***33 (24)***	***41 (32)***	***74 (56)***

Focus group discussions	**# of groups**		
	Male	Female	Total
VHSNC (general community, ASHA, AWW, ward)	4	8	12
Non-VHSNC (general community)	3	3	6
Total focus group discussions	***7***	***11***	***18***

While Table 14 presents the data divided into the categories of VHSNC member and non-VHSNC community members, the village-level reality complicated this distinction. Some people officially listed as VHSNC members were unaware that they were on the committee; some agreed to join and attended a few meetings but then stopped participating. AWWs were supposed to be VHSNC members by default, according to MoHFW guidelines, but some did not consider themselves members. ANMs were supposed to be included as a member of the VHSNC in the village they resided in, however in our research area no ANMs lived in the villages so no ANMs were members of VHSNCs. All commuted long distances from the nearby city, largely because none of the health sub-centers (in which they are supposed to reside) had electricity, water, or residential quarters.

Our focus group discussions with general community members frequently included VHSNC members, although these members were often inactive. Similarly, non-VHSNC members often joined VHSNC focus group discussions. It was socially impolite to insist on excluding people who appeared and we decided it would have been more detrimental to our research to enforce exclusivity, especially when VHSNC and non-VHSNC identities were themselves fluid.

We observed 54 key VHSNC activities over the course of the intervention, including NGO staff trainings and meetings, village level mobilization about the VHSNC, monthly village level VHSNC meetings, and quarterly cluster level meetings (which involved two to three representatives from each VHSNC in a cluster of 17 villages).

Each observation session was documented based on our observation guides, which sought to assess features such as participation (e.g. how many people, gender, caste) and group dynamics (e.g. who spoke, who was silent, where people sat).

The interviews and focus groups were conducted in Hindi, primarily by GP (a co-author), an Indian male researcher who resided in Manujpur for the research period. Data collection was closely supported by SM (a co-author), a female Indian researcher, and KES (first author), a female Canadian research coordinator. All researchers had master's degrees in public health or social science subjects and were trained in qualitative research methodology. The three on-the-ground researchers (GP, SM and KES) debriefed after almost all data collection and maintained extensive research diaries.

Interview and focus group topic guides focused on: the village context (gender and caste relations, prior collective action, engagement with government services), VHSNC embeddedness and inclusiveness (reasons for participation and drop out, support or lack of support for participation, how others in the village respond to VHSNC members), VHSNC activities (experiences in VHSNC meetings and trainings, issues discussed, which members speak more and less, how the committee manages administrative processes) and public system responsiveness (how authorities respond to the committee, committee successes or frustrations when seeking change). Interviews and focus group discussions were audio recorded with the participants' signed consent and translated and transcribed into English by several

translators. All translations were checked closely by SM and GP then approved by KES.

6.3.3 Data analysis

Analysis of the data was informed by thematic content analysis (Attride-Stirling 2001). We began with a close reading of all the transcripts, observation notes, and memos. We then developed a coding framework based first on *a priori* research interests in VHSNC embeddedness (e.g. VHSNC member dialogue with community), inclusiveness (e.g. democratic selection of members) and activities (e.g. meetings attendance, barriers to attending, motivations to attend). This framework was expanded to capture emergent content by selecting three rich transcripts (one focus group discussion and two in-depth interviews) and adding emergent codes whenever no *a priori* code was appropriate. For example, we created the code "speaking up" to capture discussion on who speaks, who is silent, and why certain people cannot speak at meetings. Emergent codes were selected through open coding (Yin 2016) on a concept-by-concept basis. The expanded framework (i.e. *a priori* codes plus emergent codes) was applied to two additional transcripts by KES and SM, who then discussed how to clarify and adjust codes further. This framework was then applied to all the transcripts by KES and SM, assisted by the qualitative data management software ATLAS.ti.

After coding, we generated outputs that enabled us to read all the quotations as clustered by code, so that higher level "organizing themes" could be identified (such as "female perspectives being heard in the VHSNC"). These organizing themes were developed and substantiated with example quotations in a long form report. For this paper, to explore how power inequalities were mediated through the VHSNC, with the social costs and opportunities resulting from participation, the long-form report was re-examined using the conceptual lens of social spaces. As a theory emerged on how the social space of the VHSNC generated possibilities for identity and discourse, KES re-read the coded outputs and organizing themes specific to gender and notions of responsibility for social services. This re-reading ensured that counter-narratives and alternative explanations were considered and reconciled into the overarching argument of the paper.

6.4 Findings

We first examine how participation in the VHSNC interacted with social inequalities within the community, focusing on gender. We identify opportunities for women to construct more empowered identities but also consider social costs associated with struggling against norms. Second, we explore a key tension between the community and outside stakeholders in relation to the construction of a dominant discourse of local responsibility.

6.4.2 Mediating power inequalities within the community

- **Overview of power inequalities in the village**

Pre-existing gender norms in the region perpetuated a patriarchal system that disproportionately limited women's decision-making power in the household, access to education, freedom to move around the village, and even access to food (and have been documented extensively by others, cf. Balarajan, Selvaraj, & Subramanian (2011), J. Dasgupta, (2011), Jeffery & Jeffery (2010), Jeffery (2014), Nagar (2000), O'Reilly (2007; 2006)). Women reported that men had much more leisure time while women managed all domestic work, childcare, and care for animals, in addition to working alongside men in the fields. An anganwadi worker pointed out that women (even those in her own family) were not excused from any work when pregnant, and were not able to receive the recommended nutrition:

> In farming, pregnant women don't get rest as prescribed in newspapers and media. They also don't get the nutrition prescribed to keep mother and baby healthy. In the village they are just supposed to work, if they don't work there are fights. (Shadeeka, female, AWW, OBC Hindu, IDI_VHC_43)

Girls were reportedly fed less than boys and pulled out of school at a younger age, although some respondents claimed these practices were prevalent among others in

their village, particularly among Muslims, and were not practiced in their own family.

> Sir, this is a Muslim area. They do not educate girls. They discriminate a lot against girls. They think a girl would not make them happy, but a boy would… They give less food to the girl. If the child asks for food, they are told to have a little bit because it is not necessary to feed the girl (ASHA, female, Sojjanpur, IDI_VHC_04,)

Violence, gambling and alcohol consumption were an issue for some women:

> They [men] drink and gamble. If they win in gambling then they drink. And if not, then they beat us [women]. This is the story of all households in the village. (ASHA, female, MO village, FGD_VHC_04)

Women in all the case study villages went to great lengths to ensure that men in their village did not hear them speak and did not directly look at their faces (called *purdah*). Women—both Muslim and Hindu—remained silent in the presence of male community members, covered their faces with a shawl (called *ghungat*) and lowered their heads or turned towards a wall whenever a male relative was nearby. This norm was described to us by men and women as signifying female respect or

shyness towards male community members. Even within families, women communicated with male relatives by asking children to serve as go-betweens.

> *Respondent (male)*: We have *purdah* system here. Women feel shy in the presence of men and they don't say anything.
>
> *Interviewer (male)*: They don't speak to any men in the village?
>
> *R*: No. [*I*: Ok.] Wives of men younger than us don't speak at all in front of us… They feel shy and don't speak and observe *purdah* system. Even at home, they don't speak directly to us. They ask children to convey messages, like 'Tell your uncle to do this.' (Jhorkibas, male, Muslim, IDI_VHC_50)

Women always sat on a lower surface than men, generally squatting on the ground while men sat on chairs because "it doesn't look proper" for men and women to sit on the same surface. These practices were not performed in interactions with outsiders, such as the male researcher GP and male NGO staff (who were from nearby villages) women sat on chairs across from them, and could speak directly to them without a shawl covering their faces.

Women, and particularly younger women marrying into their husband's family, had very limited power both within the family and within local governance. The local elected system of government (the panchayat) reserved one-third of all positions for women. However, men and women openly reported that whenever an area had to elect a female candidate, the names of women would be placed on the ballot as a proxy for their male relative, who performed all government functions in place of the elected woman.

While gender was a more obvious shaper of identity, family wealth, caste status, and religious group (Hindu or Muslim) also affected identity performance. These aspects of identity were expressed in innumerable ways, including: the people with whom you could speak, which parts of the village you could enter, whose foods you could eat, and the community roles for which you were eligible. For instance, higher caste people would not eat food or drink tea served by lower caste people and in some instances, when a group was seated together on the ground, higher caste people would sit on a rug while lower caste people sat on the bare floor. Furthermore, the intersectionality between gender and these other features of identity was visible in these villages. Lower caste women in some villages had to ask higher caste women to fill their water vessels for them, since lower caste people could not touch the tap. Higher caste women in some villages had greater limits placed on their movement as they were expected to move only within the sphere of their family's home and land and to avoid the lower caste areas of the village. In contrast, lower caste

women often travelled more freely around the village and fields because they had to take on more work outside the home.

- **Occupying the physical space of the VHSNC**

As an "alternative social space," the VHSNC proposed new physical configurations, particularly with respect to inviting both genders to occupy a public sphere. While the idea of having participants from all caste and religious communities come together for local problem solving resonated with pre-existing indigenous conflict management structures, bringing together both genders was largely unprecedented.

Women explained that attending meetings was often very difficult because they had endless domestic responsibilities and "complete responsibility for the house" (ANM, IDI_HS_03). It is striking then that women nonetheless occupied their physical space on the VHSNC, consistently composing over 50% of the meeting attendees, even if some female members rarely or never spoke. Men and women stated their support of women's membership, with men invoking the government's guideline that membership had to be at least 50% female as justification for including women:

> *Interviewer (male):* What is the benefit of having women in this committee?

> *Respondent 1 (male):* Women would tell their problems. And it is in the guideline to keep 50 percent women and 50 percent men.
>
> *Respondent 2 (male):* If the government has prepared norms, then 50 percent women have to be in the committee. (Sojjanpur, men, FGD_VHC_12)

Physical presence during participatory activities is only a crude measure of participation (Mosse 1994), but in this context, building new norms of gender inclusiveness was already a drastic variation from established ways of organizing gender in physical space.

While women's right to attend meetings was uncontested, the physical presence of a lower caste woman in one village, Shadeeka, was dependent on her tenacity and the presence of the NGO facilitator. The village was composed of two main caste groups and only one SC (highly marginalized) household. Of the 50 villages, seven had similar compositions, i.e. just one or two SC households. The adult female member of the SC household in Shadeeka was included in the VHSNC by the NGO facilitator without the approval of others in the village, who openly mocked and discriminated against her. Other female VHSNC members said that the SC woman was allowed to remain on the VHSNC only because the stakes were low, as there was no salary for members:

> *Interviewer (male)*: But then people must have agreed [to include the SC woman in the VHSNC]?
>
> *Respondent (female):* No agreement. But then no one said anything at that time… What does it matter if it's written?... It's not like anyone is getting a salary for this. (Shadeeka, female, OBC Hindu, IDI_VHC_25)

The SC woman pursued VHSNC membership because she hoped that it would lead to a job as cleaner at the school. She reported that the other VHSNC members tried to exclude her from VHSNC meetings by not telling her about them; even when the NGO facilitator sent someone to call her, she reported that the VHSNC members told the NGO facilitator that she was not at home. She only attended when the NGO facilitator called her directly or if she noticed a meeting taking place. The VHSNC program was unable to effectively challenge this caste relationship over the course of the intervention. At times the VHSNC may have even reinforced discrimination, such as when the SC woman in Shadeeka reported that male VHSNC members discussed installing a separate water storage tank for her SC household, to avoid cross-caste sharing (female, SC, IDI_VHC_46).

In the other three case study sites, VHSNC members endorsed the need for VHSNCs to include representatives from all caste and religious communities, and attendance

at meetings met this inclusion principle, with strong representation from all marginalized groups. In these villages, our research team did not detect overt discrimination between higher and lower caste members or between Muslim and Hindu members at VHSNC activities. For example, VHSNC members shared the same rug during meetings, shared food during training sessions, and spoke together about health issues without distinguishing between issues by caste groups—at least to an extent that we could detect. However, we recognize the subtlety of caste discrimination and note that this area requires additional exploration. The NGO staff modeled non-discrimination in key ways: the team included a Muslim facilitator and facilitators from non-marginalized castes who created norms of inclusiveness. For example, the NGO staff pro-actively invited all members to sit on the rug together, sought inputs from all members, and distributed food at the trainings without any segregation. In one instance, a higher caste VHSNC member suggested to a higher caste NGO staff member that separate water containers for higher and lower caste people be used during a training. The NGO staff member replied that that everyone who comes to the NGO's office or training center, including himself, shares the same water container. The VHSNC member accepted this response and shortly after took water from the communal vessel.

The opportunity created by the VHSNC for expanding women's ability to occupy public space alongside men was somewhat diminished by the normative justifications given for this policy. This co-occupation of participatory space was integrated into pre-existing gender norms that valued women for raising children

and valued men for assertiveness. Men and women explained that women belonged on the VHSNC because they were responsible for children's health and birth control:

> [The VHSNC] is also about immunization of children. Ladies know more about it. Gents usually work in fields… So I think, if the preference is there, it is beneficial. (Hanwari, elderly male, ST Hindu, IDI_VHC_54)

> Women are the ones who consider everything. 'Health Committee' means it should look after health and women are the ones who face the most health problems. Whatever is there, whether it is delivery, sterilization, immunization, whatever it be, health related work is more in women. (ANM, Shadeeka, IDI_HS_03)

Similarly, male VHSNC membership was grounded in male gender expectations of assertiveness and access to spaces outside the village. Whereas women could not speak up, men could go out and demand change: "Men at least know that, sir, if something doesn't happen, then, 'We can make some noise.' That is the thing." (Sojjanpur, male, IDI_VHC_21). The AWW in Hanwari (IDI_VHC_12) noted that male members would help the committee function, because they could go outside the community and "voice our concerns." Similarly, women in a focus group discussion explained that men could talk to others, whereas no one would listen to women:

Woman 5: Gents should also be there [in the VHSNC].

Woman 6: Who will listen to the ladies? We need some support from men. Only the men can talk with men and other people. (Shadeeka, women, FGD_COM_03)

Thus the VHSNC created at least some limited opportunity to challenge gender norms that segregated men and women and excluded women from physically attending public discussions. However the underlying gender norms that limited women's scope beyond a domestic role and excluded men from taking up reproductive health issues were left unchallenged in many cases.

- **Some opportunities to re-negotiate gender norms through action**

While justification for both genders to be involved in the VHSNC reinforced entrenched gender norms, as discussed above, VHSNC policy and some VHSNC members' behavior also challenged these norms.

MoHFW guidelines designated the role of VHSNC secretary to the (female) ASHA, which demanded capacities unrelated to a domestic or maternal identity: public speaking, leadership, literacy and numeracy, and calling all the members together for meetings. Many ASHAs struggled with this role, particularly because they could

not speak to the men to call them for meetings or lead the meetings. For example, an ASHA initially said that the VHSNC would not function without support from her village's NGO facilitator:

> Because when he [NGO facilitator] calls, two-three men gather. If I go to call people only two-three women come, they are illiterate. So in this way it cannot work. Most of them don't come if I call them (Jhorkibas, female, ASHA, OBC, IDI_VHC_29)

However the NGO's support and training enabled some ASHAs to envision themselves taking a more active role. Six months after the ASHA just quoted above explained that she could never convene the VHSNC meetings without the NGO facilitator, her confidence had grown and she envisioned herself performing the NGO facilitator's role:

> *Interviewer (male)*: Okay, like you were saying that [NGO facilitator] does all the talking and writing work. If he doesn't come; who will do it?
>
> *ASHA*: ASHA will do it.
>
> *I*: You will do it! Okay. But see, you don't talk with men then

how will it be possible?

> *ASHA*: Then we will do it. I am saying then we will do it. Right now we can see that he is doing it. When we have to, we will do it. We will have to do the meeting and we will have to raise the issues. (Jhorkibas, female, ASHA, OBC, IDI_VHC_48)

While this growth in self-assessed capacity is striking, additional research is required to follow up on how the ASHAs managed after the NGO facilitators stopped coming. This research could explore not only the extent to which ASHAs gained the capacity to take on these leadership functions, but also how the communities accepted the ASHAs' performance of these roles.

Beyond policy stipulations on the ASHAs' role, we also found that female VHSNC members began taking action outside the VHSNC on issues beyond reproductive and child health. In particular, following the first round of VHSNC training, some female VHSNC members worked to improve the village schools, which were staffed by male teachers from outside the community. In one village, female members of a VHSNC demanded that girls be admitted to the local school through a government scholarship program designed to help girls access secondary education. In another village, a female VHSNC member demanded that the male headmaster release the government's grant money to enable her daughter and other girls to buy bicycles:

> VHSNC member Rashmi's daughter had not received money for her bicycle. Rashmi followed up with the headmaster several times so eventually he said to Rashmi, 'Tell me your daughter's name and take her cheque but don't disclose this to anybody.' Rashmi said to headmaster, 'I have 22 daughters studying here in this school. So you have to give their respective money to all.' After three days, the headmaster gave the bicycle money to all the girls. (Observation of VHSNC cluster meeting in Sojjanpur, respondent from neighboring village, OBS_VHC_15)

Rashmi refused to accept the headmaster's offer of assistance for her daughter alone, instead advocating for all the girls in the school. By presenting herself as "mother" of all the 22 girls in the school, she may have gained persuasive power from the dominant discourse that valued women primarily through their maternal role. At the same time she took up a very public, non-domestic, position and successfully advocated for all the girls at the school.

Another female VHSNC member in Sojjanpur village discussed women's capacity to challenge the teachers for "lazing around" and "playing cards" in the day. She explained that because of the VHSNC, teachers are aware that women may come and demand better behavior:

> It is because of these meetings that we can move forward… Otherwise we can't even climb up to the gates of the school… So teachers also get to know sometimes that if any ladies come, they feel we can also be in control. Because of this we participate. (Sojjanpur, female, Muslim, IDI_VHC_38)

Male VHSNC members tended to take action within accepted masculine spheres, primarily by raising requests to government agents for a range of issues. They focused most attention on improving access to potable water, an issue prioritized by men and women, but also sought improved primary health services, which tended to be most important to women.

Several men took interest in monitoring anganwadi services, a traditionally feminine domain. Male VHSNC members reported that they checked the center to see if food was being provided to children. However, their monitoring was solely visual, since they could not converse with the (female) anganwadi staff:

> *Interviewer (male):* Ok. So when you reached there, what did you tell them? Did you talk to the anganwadi worker?
>
> *Respondent (male)*: No, sir, there was no conversation. It was just seen that she was making children eat *khichdi* [soft cooked rice]. There were small children. They [anganwadi

> workers] can't speak. So I just saw that everything was all right and left... I can't stay there. You know the women of the village feel shy. They do *ghungat* [covering the face with cloth in front of men]. So I don't stay there. (Jhorkibas, male, SC Hindu, IDI_VHC_44)

The VHSNC thus provided both men and women with some opportunities to expand the acceptable male and female spheres of action.

- **Claiming voice in the VHSNC**

NGO staff made efforts to move beyond female attendance, to actually including women's voices in the VHSNC. In VHSNC meetings and trainings, female members sat clustered together, often whispering among themselves quietly. NGO staff encouraged women to present their views by directly asking them questions and sometimes teasing them with comments such as, "We have female chief ministers in India and yet you won't talk?" Although seemingly innocuous, the NGO staff's demands for female participation had both transformative and dangerous potential. By suggesting that female participation in front of men may be normal and expected, the VHSNC space could be a site of renegotiating gender norms for greater female influence. It also could have enabled women who wanted to speak up to do so, under the guise of having been forced by the NGO facilitators. However, the NGO staff's efforts to make women speak also pushed women to violate norms, which could

have negative consequences for women upon leaving the "alternative space" of the VHSNC.

Women managed this risk in several ways. Sometimes, women offered quiet one-word replies to deflect attention without overtly ignoring the NGO facilitator's request. But often the group of women (including the ASHA) discussed issues amongst themselves and then the ASHA presented their opinion. Male VHSNC members appeared to accept this micro-violation of gender norms, perhaps because men recognized that the NGO facilitator had forced the point, rather than the women themselves having exhibited boldness and a desire to be heard, which would have been unacceptable. In addition, it was accepted as appropriate and necessary that ASHAs occasionally spoke up in front of men because AHSAs held government positions as health workers.

ASHAs were seen as uniquely able to perform this role because it was expected of them as a part of socially valued (governmental, salaried) work, and thus acceptable. Some were credited with having unique traits that further enabled them to speak in front of men, such as greater intelligence, wider experience beyond the village or origins in difference parts of the state:

> *Respondent (woman):* Uma… she speaks in front of everybody. I can't do it. Everybody here is her elder too, like her father-in-law…. But she speaks, even from inside the veil.

Interviewer (male): How does she manage speaking then?

R: She is originally from a different area and so she is smarter, so she speaks. I cannot do it.

I: Are you afraid?

R: No, not afraid, But we have never spoken in front of them. Like right now I am speaking…. If my father-in-law, who is asleep now, if he was here, how could I have spoken? In meetings, some of my elders are present… So she speaks out, I can't. Even when there are heated arguments she speaks out, I feel hesitant to do like this. We are not this open. (Shadeeka, female, OBC Hindu, AWW, IDI_VHC_43)

We also witnessed very occasional "slippages" in gender performance (Butler 1988), when female VHSNC members who were not ASHAs interjected in meetings. For example, in a meeting a female VHSNC member told a story about a woman in labor who delivered a dead baby boy while waiting for the ambulance to reach the village (Sojjanpur, OBS_VHC_29). As the possibilities of gender are "necessarily constrained by available historical conventions," (Butler 1988, 521), these instances where

female participants failed to re-enact aspects of expected gender behavior pressed the boundaries of acceptable performance.

Challenging dominant gender norms within the alternative space of the VHSNC did not protect women from experiencing consequences outside the space when they returned to everyday life. Informal social processes, enacted by both men and women, police gender performance to maintain the status quo. An NGO facilitator (female, general Hindu, IDI_OTHER_05) explained that in one village, women were scolded at home for speaking up about their water problem in a meeting. She felt that Muslim women were particularly constrained and added that they were no longer allowed to participate at all:

> The Muslim women were coming for the meetings and at times they even went for training… [But] if they put forward some viewpoint of their own, at times it so happens that they get scolding back home for saying such things… They [family members at home] said 'now no one will want to marry the girls in our family. We will have a bad name in the village.' Now the women are not allowed to come for any meetings (female, NGO facilitator, IDI_OTHER_05).

Another facilitator (female, OBC Hindu, IDI_OTHER_06) said that women were afraid to speak "because they think that after meeting the men can say that you were

speaking too much." In one instance, men openly expressed their discomfort with subtle challenges to gender relationships within the VHSNC. When NGO staff made an additional effort to encourage women to attend trainings, men laughed at the prospect of women taking leadership roles, seeking to reinforce the absurdity of the concept: "Women will take the training, will work as officers in the committee, and we will be their peons. [All laughing]" (M5, Hanwari, men, FGD_VHC_06). Further research should be conducted to assess the extent of this problem, by more comprehensively tracking how frequently women faced reprimands or other negative consequences as a result of participating in the VHSNC.

While participatory spaces such as the VHSNC are just another arena to perform in, they can provide a place for people to "rehearse for reality" through exploring alternative social interactions (Kesby 2005b, 2039 in; Welbourn 1998). The transformative potential of VHSNCs to serve as "other spaces" where new identities are rehearsed is constrained by the limited time in which participants enter the space and the participants' acute awareness that they have to return to their everyday power relations as soon as the meetings end.

Gender roles were re-constructed beyond the VHSNC's physical space, when female members asserted community rights at the local school and male members took an interest in the anganwadi, indicating that a social identity as "VHSNC member" enabled new interactions with government institutions but did not radically redefine gender interaction among community members. Nonetheless, the process

of social change is primarily a series of micro-transgressions of norms, each of which presses the boundaries of acceptable performance and all of which, over time, add up to alternative norms. The VHSNC created such opportunities for change as female, and occasionally male, VHSNC members re-interpreted their social roles.

6.4.3 Mediating power inequalities between the community and outside actors

Power inequality between the community and outside actors manifested most starkly in a struggle to construct a "discourse of responsibility" for improving health, sanitation, and nutrition in the villages. According to Foucault (1980), power works in society through discourse and practice—domination is achieved through making ideas and practices that benefit the elite "common sense", true and self-reinforcing thus making power and knowledge inseparable. The more normalized a discourse becomes, the more effective the power system (Kesby 2005b).

This section first explores how the VHSNC served as a social space that outside elites constructed, replete with a dominant discourse that limited possibility in a way that benefited the outside actors. We then describe the ways in which community members resisted this discourse, manifested in refusals to occupy the VHSNC space. Third, we discuss the high social cost of accepting the discourse, which led VHSNC members to construct their peers as selfish and their village as fundamentally lacking the positive attributes that would enable residents to live up to their

responsibility. We suggest that the power inequality between community and government actors around the VHSNC limited the VHSNC's opportunities to construct an empowering alternative discourse.

- **The dominant discourse**

The VHSNC strengthening intervention hinged on the government constructing a discourse of local responsibility, which was conveyed to the communities through SEEK, the NGO contracted to implement the intervention. The MoHFW guidelines, the NGO staff, and the block level system functionaries sought to present the VHSNC as a viable participatory body by framing VHSNC members as actors responsible for and capable of affecting local change. If community members were not responsible for solving local problems, there would be little reason for local people to participate.

The MoHFW VHSNC guidelines suggested that the VHSNC focus on household and village level health action, recommending that members "gather and clean the village" and "organize teams for source reduction work" to stop mosquito breeding. It also positioned the VHSNC as capable of acting to improve local health through "informing local authorities" so that "health care delivery and public services are improved upon" (MoHFW India 2013a, 42). VHSNC members experienced many interactions with health staff that reinforced local responsibility. For example, the

Block Chief Medical Officer (BCMO) told VHSNC members that they were responsible for overseeing the ANM:

> *BCMO*: At the sub center you have the responsibility of asking the ANM where she is working, the status of medicines and the care given to pregnant women and children. It is also the VHSNC members' responsibility to be aware of the services available at your sub center. For the example sub center should be open from 9 am to 11 am and in this time period sick people can go to the center and gain health services. (Observation note, VHSNC cluster meeting, OBS_VHC_24)

SEEK staff suggested the VHSNC could take responsibility for checking the functionality of the Manujpur hospital and for having health worker vacancies filled:

> *SEEK director (female):* Here decentralization has the advantage that people or committee members have the authority to monitor these local institutions. For example, in the Manujpur CHC, the government is providing Rs. 30,000 [US $550] for cleanliness. But can you see the outcome of that money? That CHC is always dirty. Here it would be your responsibility to check that the hospital is functioning the way it should be.

> *SEEK field manager (male):* There are many problems in the health sub-centers, such as whether an ANM is appointed or not. If an ANM is not appointed, it the responsibility of the committee is to write a proposal to the government for ANM appointment. (observation note, VHSNC cluster meeting, OBS_VHC_31)

Most meetings, led by the NGO facilitators, focused on identifying service gaps and writing requests to the authorities to address these gaps. Whenever VHSNC members were able to speak to government agents, members made requests for a range of village level service improvements, such as for health workers, medicine and equipment at health centers, and improved water, drainage, roads, and waste management. Overwhelmingly the government response focused responsibility back on the VHSNC by telling members to write additional requests to higher level government agents, to follow up with departments, or to solve the problem themselves. For example, male VHSNC members said that they have reached out to officials about sanitation issues "many times" but that they are always told to fix their own problems: "they say that the place belongs to you so why don't you remove it [waste and stagnant water] by yourself?" (Sojjanpur, men, FGD_VHC_12).

- **Resisting the discourse**

Many VHSNC members, particularly male members who stopped participating, resisted dominant claims of local responsibility. VHSNC members provided numerous examples of upstream problems that VHSNC membership had no capacity to solve. They explained that the VHSNC brought no new political power for local people to demand change from the government and no new financial capacity for local people to fix problems themselves. They rejected the idea that any village problem could be solved by village residents taking responsibility, noting that improved water access required expensive development beyond the village's means, that stagnant water gathered because of poor drainage infrastructure, and that improved waste management required the public works department to clear large open air garbage piles.

For instance, in a focus group discussion with men who refused to attend VHSNC meetings, the group derided the notion of lending their time and energy to direct civic maintenance, asking: "What to do on sanitation? Shall we take brooms individually and make the village clean or what?" (Hanwari, male, FGD_VHC_06). In a meeting, a VHSNC member explained that they had exhausted the avenues available to them to seek an ANM, and suggested that responsibility lay with politicians:

> *Male VHSNC member*: Nothing is going to happen. We have been waiting for six years in our village, but ANM recruitment still has not been done. The CMO [Chief Medical Officer] clearly said recruitment will only be done with the help of politicians. So whom should we consult with? We don't have money to go to [state capital] or Delhi. (Observation note, VHSNC meeting, Shadeeka, OBS_VHC_24)

Another group of male VHSNC members explained that they needed departmental support, and pointed out that the administration avoids responsibility by telling villagers that the community must take up the work: "the administration gets away with inaction by saying that this is your work" (Sojjanpur, male, FGD_VHC_12). The men spoke at length about the need for greater government engagement in the VHSNC:

> *M3*: The truth is one person cannot do anything. Our committee cannot do anything. The village is also with us but until the department is with us nothing can be done.
>
> *M1*: True
>
> *M3*: If the department is with the committee, then there will be a solution. But neither PHED [Public Health Engineering

> Department] is with us, nor the PWD [Public Works Department] nor the Health Department is with us. (Sojjanpur, men, FGD_VHC_12)

The extent of this resistance among men was significant, going beyond a few disillusioned individuals, although never reaching a majority opinion. It remained more common for people to accept the discourse of responsibility, but blame their peers (discussed next), or to generally say they were reluctant to participate because the VHSNC's discussions had not resulted in any changes, without identifying precisely why. Some respondents also presented several of these perspectives over the course of one interview.

- **Accepting the discourse had high social costs for the community**

Many VHSNC members felt that the discourse of local responsibility resonated with their worldview. As such, they placed enormous blame on their community for the fact that local problems had not been solved by the VHSNC. Many agreed that if only the village had sufficient "social feeling" and initiative (male, ST Hindu, Hanwari, IDI_VHC_54), then a great amount could be achieved through the VHSNC.

The fact that the VHSNC were perceived to have achieved very little was thus blamed on the "stinginess" (Jhorkibas, male, Muslim, IDI_VHC_50) of people in the village, who were only willing to work if there was money involved and dropped out

of the VHSNC when they "realized that they will not get anything" (Jhorkibas, ASHA, IDI_VHC_29). A male VHSNC member blamed the community's "lack of initiative" for the fact that the untied fund was never released for their use, although the VHSNC wrote numerous requests and asked a number of government agents about the money:

> In the meeting we were informed about the fund, but the members do not take initiative or responsibility to know whether the money has been transferred or not, and how to use the same. (Sojjanpur, male, SC, IDI_COM_06)

Accepting the dominant discourse of local responsibility was reconciled with disappointing progress by reproducing a negative local identity. In other words, those who accepted local responsibility for improving village health, sanitation, and nutrition had to find ways to explain why so few improvements occurred. They did so by blaming their peers for lacking the positive attributes necessary to fulfill this responsibility. Respondents blamed their peers for being "backwards" and not caring about social progress: "[people] do not pay much attention towards all these things" because "this is a village, this is not some city. People speak like this only in the village" (female, SC, Hindu, Sojjanpur, IDI_VHC_25). One VHSNC member maintained that the committee had achieved "nothing," because "the villagers, they want to remain backwards, so they stay backwards. However much you bring them forward, they don't progress much" (Shadeeka, female, IDI_VHC_25). A man said

that overall the village had "no unity" (male VHC member, Muslim, Jhorkibas, IDI_COM_06). In a focus group, a woman claimed that "everyone is selfish here in this village" to the wide agreement of the others, despite examples of families working together to help people reach the hospital or access water (Shadeeka, women, FGD_VHC_05). A male member blamed "illiterate" women who "cannot understand things" for throwing their garbage in public spaces of the village, despite later noting that there was no alternative waste management system in place (Sojjanpur, male, SC Hindu, IDI_VHC_45). Overall, he felt that the "progressive" and "literate" people in the village, most of whom participated in the VHSNC, were up against a majority of "illiterate boors", who impeded efforts for bettering the village (Sojjanpur, male, SC Hindu, IDI_VHC_45).

Accepting the dominant discourse of local responsibility thus had a high social cost. If the VHSNC was truly responsible for improving the village, the only way to explain poor outcomes was to blame one's community for failing to take up this responsibility and improve the village. This perceived failure then reinforced a sense that nothing could improve because of the community's collective failings.

This research joins the work of Marsland (2006) in exploring how power inequalities between elites and community members can result in divergent (and contradictory) understandings of community participation, with negative effects on marginalized communities. Marsland found that Tanzanian participants on community malaria control boards also became increasingly disparaging of their

peers. She noted that these negative opinions of one's peers arose as malaria board members adopted the language of elites, who explained the poor health of marginalized people on their incapacity to solve their own problems.

Cornwall (2002) distinguishes between invited and claimed spaces for participation. VHSNCs are invited spaces, created and defined by dominant actors (the state, through a contracted NGO) into which community members are invited to enter and participate. Spaces for participation developed by elite actors tend to generate agreement around pre-determined agendas and further a dominant discourse (Mosse 2001). Our findings substantiate Mosse's concern, illustrating how the dominant discourse of local responsibility was accepted as "truth" by many, which reinforced negative community identity. However, the transformative potential of these social spaces also stems in part from Foucault's theory of power as a disparate and creative force, abounding with resistance (Foucault 1980). As such, the justification for the VHSNC was contested by others, who proposed an alternative discourse of upstream responsibility. This resonates with Mosse's findings, which highlight community agency in resisting or subverting the agendas of participatory development programs (Mosse 2005).

In resisting the dominant discourse, many men refused to take collective responsibility for village health, sanitation, and nutrition issues and many explained that they would no longer attend VHSNC meetings. They presented extensive evidence of the need for upstream government agents to intervene. Accordingly, this

resistance, no matter how compelling and justified, removed any agency from the community and ultimately left the status quo unaltered. Some VHSNCs did take local actions to support or monitor the anganwadi worker and schools, and to affect change, or to coordinate political efforts to push for improved services. There is a need for renegotiating the discourse around VHSNCs to create space for communities' legitimate anger at poor services and desperate need for improved upstream support, without closing the possibility for smaller scale local action within the community.

Whether rejecting or accepting the "truth" that local people can improve their health, sanitation, and nutrition through the VHSNC, most people planned to stop participating. The lasting effects of entrenched negative views of one's community should not be taken lightly. Nor should the frustration expressed by respondents who explained that the VHSNC unfairly expected them to take responsibility for major issues beyond their control be discounted.

6.5 Discussion and conclusions

This paper asked "What social costs and opportunities arose through participation?" We explored this question by examining health committees as "social spaces" where power inequalities (both within communities and between communities and outsiders) may be reinforced or renegotiated.

In terms of power inequalities within communities, we identified a number of opportunities that enabled subtle challenges to pre-existing restrictive gender norms. First, requiring a mixed-gender group and expecting them to communicate about valued services (health, nutrition, and sanitation) was a radical act in a community without any other forums for cross-gender collective dialogue and decision making, even if most women did not verbally participate.

Second, some women used their identity as VHSNC members to push the boundaries of the acceptable feminine concerns and behaviors: as VHSNC conveners, ASHAs took up leadership positions, and several female VHSNC members worked together to improve girls' access to education by speaking to male teachers and headmasters. The VHSNC also made it possible for male members to enter the traditionally female space of the anganwadi center and take interest in the quality of food and care provided there.

Third, when some women exercised voice in the VHSNC, it contributed to normalizing the idea of women speaking in the presence of male community members.

It must be noted however that although the VHSNC opened up some new possibilities and enabled some women to express their own and collective female voices, for most women speaking openly in front of men continued to be unacceptable. Many female participants remained silent, cognizant of the everyday reality awaiting them outside the VHSNC, and spoke only with their physical presence. Women who pushed the boundaries of acceptable behavior—at times invited and cajoled into doing so by NGO facilitators—could not be protected from conflict upon returning home, where dominant interests were invested in sustaining the status quo.

In terms of power inequalities between communities and outside stakeholders, the discourse of local responsibility played out in VHSNCs as both an instrument of power used by outside stakeholders and as a point of resistance. Participants who accepted the discourse of local responsibility reconciled it with the lack of local action by suggesting that their peers were selfish and unwilling to take collective action. The VHSNC thus enacted a high social cost by re-entrenching disempowering collective identities. However, many in the community resisted the dominant discourse and sought to construct a counter-narrative that placed responsibility in the hands of upstream government functionaries.

There are two central implications of these findings. First, participatory programs such as the VHSNC can create some opportunities to challenge power inequalities within communities, even in contexts with rigid gender norms such as Manujpur. Facilitation by the outside NGO staff emerged as essential to constructing VHSNCs as "alternative social spaces" (Kesby et al. 2005) where unfamiliar rules and alternative possibilities can be ascribed. This finding is a valuable affirmation of the transformative potential of this type of participatory program, in light of concern that participatory programs are highly prone to elite capture and the exclusion of more marginalized people within villages. However, we must be cautious not to overstate the potential of these micro-disruptions to within-community power relations. Women and lower caste people continue to face major macro-level barriers (including poorer access to education and enormous financial constraints) to full participation and self-determination in the decisions that affect their lives.

Second, greater attention must be paid to the fundamental link between participation in VHSNC activities and genuine empowerment through gaining control over the resources needed for increased opportunities. Campbell (2014) highlights that decades of community mobilization work have focused on empowerment to overcome symbolic aspects of oppression (such as negative self narratives, lack of collective spirit in communities) without adequate attention to the materialist roots of oppression (i.e. economic inequality). Just participating in meetings and discussions of health, sanitation, and nutrition issues is of little value

without the tools to address these issues. Moreover, it is unsustainable. Participatory social spaces such as VHSNCs can only have transformative potential if they are occupied by community members and thus continue to exist—and community members will only occupy these spaces if they are a means to gain resources and reduce power inequalities between themselves and outside elites. As we saw, people resist dominant discourses that fail to resonate with their worldviews by avoiding the spaces where those discourses prevail. The men and women whose participation in the VHSNC created spaces to challenge within-village power inequalities were unlikely to continue participating in the committee unless it brought concrete improvements.

Interventions to strengthen VHSNCs must support social transformation not just inside the VHSNC but also beyond the VHSNC in other village level institutions, and between communities and elites. The VHSNC can serve as a space in which participants can "rehearse for reality" (Welbourn 1998) by practicing alternative gender and caste relationships, and strategize about how they can build their influence beyond the village (such as how to petition government officials). But additional resources and support are required to then enact these alternative norms in reality.

Power cannot be avoided but is *always* at play in social relations and thus must be thoughtfully utilized to promote social justice (Kesby 2005b). Examining how power inequalities work through participatory spaces can thus enable the creation of

participatory programs that better engage with the problem of power inequalities. Great potential to extend the VHSNC's transformative potential lies in strengthening the committee's economic and political power while at the same time sustaining the gender and caste co-occupation of space and continuing to build women's voice on the VHSNC. VHSNC policy thus needs to clarify and strengthen the linkages between VHSNCs and outside actors, such as the panchayat and government officials, and ensure VHSNCs can access funding. As VHSNCs gain greater power, the stakes associated with VHSNC participation may rise. More powerful members may try to edge women and lower caste people out and the social risks associated with violating gender and caste norms will rise. Ongoing support through skilled facilitation will be vital to sustain gains and mitigate risks.

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CHAPTER 7. GOVERNMENT HELPER AND CITIZEN ADVOCATE? A CASE STUDY OF THE MULTIPLE ROLES AND PRESSURES FACING A NON-GOVERNMENTAL ORGANIZATION IMPLEMENTING A PARTICIPATORY HEALTH PROGRAM IN NORTHERN INDIA

7.1 Abstract

Background

Many theorists express concern that the proliferation and professionalization of non-governmental organizations (NGOs) contributes to a de-politicization of development, particularly when NGOs take up donor-driven projects or government contracts. However, NGOs have the potential to play a valuable role in strengthening citizen engagement in the public sector because of their community orientation. NGO experiences have not been adequately explored, especially their agency in managing their multiple roles as government helpers and community advocates.

Methods

This paper presents a case study of an NGO implementing a government-designed health systems intervention at the local level. We draw from observation (n=54), interviews (n=76), focus group discussions (n=18), and secondary review of written project materials. Analysis was conducted using the thematic network technique,

which enabled the identification of themes, development of connections between these themes, and detailed exploration of sub-themes.

Findings

The NGO was able to work within a challenging context of community mistrust and poor government responsiveness to successfully form and support VHSNCs over a 1.5-year period. Its "in between" status as government helper and community advocate enabled a range of positive processes, including helping communities voice concerns to government officials, and helping facilitate understanding between communities and local level government functionaries. Many of these positive processes were made possible by the NGO's respected interlocutor status in communities, pre-existing relationships, and willingness to "sell" involvement in the VHSNC as a mechanism for improving village-level health and wellbeing. However, despite enabling many positive processes, concrete improvements in the villages were often far below community expectations. NGO staff thus endured community frustration on one hand and rebuffs from lower-level officials on the other, while feeling under-resourced and under-supported by the contract. When contracted to deliver a package of VHSNC supports focused on strengthening the community, the NGO increasingly worked alongside VHSNC members to strengthen the public sector.

Conclusions

Contrary to assumptions in the literature that NGOs become "tamed" through taking government contracts, this case study indicates that when contracted to support community engagement in the public health system, NGOs take up a necessarily political process.

Keywords

Non-governmental organizations; civil society; village health committees; governance; community participation; India

7.2 Background

What challenges and opportunities arise when non-governmental organizations (NGOs) are contracted by governments to deliver community-participation interventions in low and middle income country (LMICs)? This paper focuses at the micro-level on how one Indian NGO team managed the tension between working as a government contractor and retaining its community orientation. We position our case study within the broader debate about the role NGOs play in society, which questions whether providing services through government contracts disallows NGOs from effectively advocating for broad community needs through political engagement.

The term NGO encompasses an enormous range of organizations, from large international development institutions, which are generally based in high income countries and channel resources to LMICs, to small community-based organizations working at the grassroots (Nichter 2008). The value of NGOs in development has been attributed to two capacities: an ability to fill gaps in delivering social services to communities ("service delivery functions") and an ability to challenge unequal relationships through people-centered approaches ("civil society functions") (Banks, Hulme, and Edwards 2015).

Over the past forty years, Western governments and funding agencies, led by the World Bank, have encouraged LMIC governments to shift social service provision away from the public sector and towards NGOs (Pfeiffer 2003; Banks, Hulme, and Edwards 2015). This shift was rooted in neo-liberal arguments that the public sector was inefficient and ineffective, while NGOs could provide better services at lower prices (Baqui 2008; Zaidi, Gul, and Nishtar 2012; World Bank 2000b; Gilson et al. 1994; Fowler 1988). NGOs were driven to accept these contracts for many reasons, including a mandate to alleviate suffering, an interest in accessing government funding, disillusionment with public management, and a desire to showcase high quality programs as a model to press the government to do more. However, taking up government contracts caused concern within many community-based NGOs, about losing their "watchdog" orientation, drifting away from their people-centered attributes or being stifled by the rigid reporting structure imposed

by government ministries (Zaidi et al. 2012; Kapoor 2005; Shepard 2006; Zaidi, Gul, and Nishtar 2012).

Critical scholarship on NGOs in LMICs has highlighted their movement away from civil society functions towards an increasing service delivery role through their proliferation and simultaneous professionalization and de-politicization (Kamat 2004; Kamat 2003; Ayers 2006; Miraftab 1997; Srinivas 2009). NGOs that arose from social movements and were once primarily volunteer-driven and politically engaged in addressing social inequalities, became increasingly "tamed" (Kaldor 2003): staffed by inter-changeable professionals (O'Reilly 2011), oriented toward record keeping and audits (Strathern 2000), dependent on donors, and engaged in delivering technical services (Kamat 2004; Kamat 2003; O'Reilly 2011). For example, Miraftab's research on Mexican NGOs (1997, 373) found that the:

> …Recent history of Mexican NGOs marks a major shift in their identity and objectives from de-professionlizing to professionlizing themselves, from working with the poor to working for the poor, from emphasis on opposition to search for proposition, and from empowerment to development.

Kamat (2002) tracked an NGO in western India as it shifted from consciousness raising and political organizing work to an emphasis on skills training for economic livelihood projects. An Indian NGO contracted by the Government of Rajasthan saw

its staff composition shift from higher-caste, skilled workers who had a deep commitment to social services to lower-caste, less educated workers who saw NGO work as a regular job; this shift was caused in part by senior staff choosing to leave because the new contract reduced their flexibility and time to build community relationships in favor of implementing an externally designed program on a strict timeline (O'Reilly 2011). In Pakistan, Zaidi et al. (2012, 577) documented NGOs competing fiercely for government contracts to provide HIV services, which shifted NGO focus from "areas such as client empowerment and behavioural change that demanded their innovative and client-centred skills … to areas with quantifiable clinical targets."

While most scholarship focuses on concern that NGOs often become apolitical replacements for earlier, struggle-based social movements, some theorists argue that NGOs continue to play valued and powerful roles in development. For example, Oxfam's Duncan Green highlights the acute awareness of these risks among NGO staff, and argues that NGOs exhibit agency in managing these risks and retaining their civil society attributes (Green 2012). Some suggest that NGOs can play a politically charged, rather than incrementalist, role even when working as service providers by developing a "politics of the possible" through showcasing improved alternatives to the *status quo* (Nichter 2008). For example, by providing expensive HIV/AIDS treatment in extremely poor settings, Medicine Sans Frontiers in South Africa and Partners in Health in Haiti showed that adherence was possible, which built global pressure to find the money to provide this treatment (Beyrer and Pizer

2007). Srinivas (2009, 623) highlights that social change requires a plurality of civil society formulations, with NGOs offering one valuable space for "rehearsing differing answers to questions of the public good." NGOs have a unique capacity to develop social capital within society, especially around bridging various groups into larger collectives and linking social groups across power differentials (Nichter 2008). For example, when NGOs work together as networks, they can exercise considerable power in influencing policy debates, as showcased by the unprecedented involvement of NGO networks in UN consultations on human rights, women's rights, and the environment throughout the 1990s (Shepard 2006). When NGOs work on issues alongside other civil society collectives, particularly volunteer-driven movements and trade unions, they can play a critical role in promoting social justice (Waghmore 2012; Racelis 2008).

In light of this debate, we examine how field workers in northern India experience working on a government contract to promote community participation in the health system: What does their NGO-identity enable? What are the trade offs and costs? And, more broadly, how do they manage the tension between advocating for communities and serving as government helpers?

7.3 Methods

This paper draws from data collected as part of a larger study in two states of India, which focused on mechanisms through which Village Health, Sanitation and Nutrition Committees (VHSNCs) could increase community engagement in public systems, and facilitate improved access to and quality of government health services. This paper presents one NGO's experience over a 1.5-year period, during which it implemented a government-designed VHSNC support package in rural north India.

7.3.1 Study setting

National setting: The Indian Ministry of Health and Family Welfare (MoHFW) explicitly promotes the involvement of grassroots NGOs in the public health system (MoHFW India 2013c). Five percent of the MoHFW's National Health Mission budget is earmarked for NGO contracts, which translated to Rs. 1055 crore (US $157.7 million) in 2013-2014 (MoHFW India 2013c). The scope of NGO involvement is envisioned "to move beyond reproductive and child health to a more comprehensive approach which would include community level interventions" (MoHFW India 2014b, 7). The MoHFW divides NGOs into two groups: "service delivery NGOs," which deliver health services to underserved areas (such as running hospitals or HIV testing and treatment programs), and "field NGOs," which support community

processes, including VHSNCs and associated health monitoring and planning (MoHFW India 2014b).

Village Health, Sanitation and Nutrition Committees: VHSNCs are a key component of the MoHFW's strategy to engage rural communities in the government health system (MoHFW India 2005b). Launched in 2007, VHSNCs have been officially formed in over 500,000 villages across India (MoHFW India 2013a). These committees are supposed to meet each month, develop village health plans, take action to improve local health, nutrition, and sanitation, monitor the performance of local-level health and nutrition services, and allocate a yearly "untied fund" of Rs. 10,000 (US $150). Membership brings together the village's female community health worker, called the accredited social health activist (ASHA), the anganwadi worker (a female pre-school and nutrition worker), elected ward representative in local government (called the panchayat system), and other interested community members, such as members of savings collectives and parent-teacher associations.

VHSNCs are to work closely with health system staff. These staff include auxiliary nurse midwives (ANMs), who provide immunization and antenatal care out of health sub-centers (HSCs) catering to approximately four or five villages. VHSNCs are also supposed to work with the local doctors (called medical officers (MOs)) who run primary health centers (PHCs), which are to be around-the-clock referral centers for a cluster of four HSCs, and block chief medical officers (BCMOs). BCMOs

are in charge of an entire block's (a sub-district administrative area, population ~300,000) network of HSCs, PHCs and community health center (CHC), a large facility which is to have 11 doctors and 24 additional health staff.

In 2013 the MoHFW released *Guidelines for Community Processes*, to provide additional support for VHSNCs. The *Guidelines* recognized that so far, "the outcome for VHSNC is less satisfactory" than for the ASHA program (MoHFW India 2013a, i). In many parts of the country, VHSNCs were meeting irregularly, if at all, were largely inactive, lacked training, and had little understanding of their roles and responsibilities (Dixit et al. 2008; Malviya et al. 2013; PHRN 2008). Before scaling up the *Guidelines*, the MoHFW worked with our research team and an implementing NGO, called "SEEK" (a pseudonym), to implement the intervention in a small area in order to derive lessons for scale up.

The VHSNC-support intervention: SEEK implemented the MoHFW's VHSNC support package, as outlined in the *Guidelines for Community Processes*, for a one-and-a-half-year period (2014-2015) in 50 villages, covering a rural population of approximately 68,000 people. The support package consisted of social mobilization in each village to increase community understanding of and support for VHSNCs, expanding VHSNC membership from seven to at least 15 members, training the VHSNC members, and supporting their monthly meetings and activities. After getting the committees up and running, quarterly cluster level meetings were also convened, which brought together two or three members from each VHSNC in a

cluster of 16-17 VHSNCs to encourage sharing and action among VHSNC members from a group of villages. Further details about the package and the context are presented in a companion paper (chapter 5).

Profile of the NGO: SEEK was founded in the early 2000s by a now-deceased eminent Indian civil servant. SEEK had a central office in the state capital and several field offices in highly marginalized blocks across the state. Their work focused on adolescent education through providing educational programs to supplement the public system, such as running village libraries and summer schools. They received funding from private trusts and corporate social responsibility (CSR) initiatives. SEEK's work on this VHSNC-strengthening intervention was their first government contract and first project working with the government health system.

Of the 50 villages receiving the VHSNC-strengthening intervention, SEEK Manujpur had previously run education and adolescent development projects in 31 villages. The depth of SEEK's involvement in these villages was moderate: SEEK ran small libraries or short adolescent capacity building camps rather than any large programs or infrastructure projects. Only some village residents knew of SEEK and the VHSNC-support intervention was run by new SEEK field staff, hired specifically for the VHSNC intervention.

The study worked with the SEEK field office in a block called "Manujpur" (a pseudonym), which had been set up in 2008 and was staffed by a director, senior

manager, six field staff, an accountant, and an office support worker. The SEEK Manujpur office was a simple five-room cement house located at the edge of Manujpur town (population 11,000). The office had overhead fans to help with the heat that could reach 49 degrees Celsius, and also a computer, Internet connection, TV, basic kitchen, electric water filter, several indoor toilets, a desk and chair for the director, mats on the floor for meetings, and four NGO-owned motorcycles parked outside. The walls were covered with shelves of youth education materials, project documentation, and village profiles as well as maps, a white board, and inspirational posters on the importance of women's access to education. Electricity cuts were frequent.

Profile of NGO's VHSNC intervention staff: The VHSNC-support project was implemented by the director, manager, and three field staff. The director, a general caste (non-marginalized) Hindu woman in her 40s, had moved to Manujpur from another district in 2014. With post-graduate degrees in library science, law, and public administration, she had worked as a block level administrator within the government, and on water and education projects with several NGOs. The manager was a local general caste Hindu man in his late 40s, with over 15 years of social work experience in the block, focused on the right to education. The field staff were all in their early 30s. One was a Muslim man from a nearby village with a post-graduate degree in social work and extensive volunteer experience in youth education. The other two were Hindu women ("other backwards caste" (OBC) and general caste) who had married into local families and resided with their in-laws.

Neither had education beyond class 11 (11th grade) and both had worked for several years on education and literacy projects in the area.

The field staff, although locals living in Manujpur, did not have the time to build extensive rapport in villages before beginning social mobilization on VHSNCs because SEEK was expected to form, train, and facilitate regular VHSNC meetings within a year (SEEK's contract was later extended to 1.5 years). SEEK field staff conducted one preliminary visit to each of the 50 village to build a social profile of the population and services available. The second visit consisted of social mobilization, which involved gathering residents together, explaining the VHSNC, and inviting people to become members. The SEEK manager, who was well known in some parts of the block, attended many social mobilization activities with the new staff to help them.

Social overview of the region: According to the 2011 Indian census, there were about 200 villages in Manujpur Block, with an average population of 1300 per village. The population was approximately 17% scheduled caste (SC) and 12% scheduled tribe (ST). While male literacy was reported at 80%, female literacy was only 50% and had not improved since the 2001 census. Based on its own data collection, SEEK estimated the Muslim population at over 20%, with literacy among Muslim women as low as 13%. Most residents were poor farmers who raised buffalo and grew mustard, wheat, and sorghum on small plots of land or worked as migrant laborers in farming, construction, or driving.

The region was extremely poor and resource-deprived. Roads were potholed and nearly impassible during monsoons; schools, anganwadi centers, and health facilities were crumbling; toilets were rare; and water and electricity were limited. The public health system was extremely understaffed. According to government norms, one ANM should serve approximately five villages, but in this region, ANMs covered 15 villages or more – triple or quadruple the maximum number of villages they were expected to reasonably handle. Several PHCs had no staff or operated with one or two staff members when there should have been at least 13.

7.3.2 Study design

Throughout SEEK's implementation of the VHSNC support package, a team of researchers led by the Public Health Foundation of India (PHFI), with support from the National Health Systems Resource Center (NHSRC) (a government organization that provides technical advise to the Indian MoHFW) and the Johns Hopkins Bloomberg School of Public Health, conducted an in-depth implementation research study. The over-arching aim of the study was to understand the contexts, pathways, and mechanisms that impeded or facilitated intensified community engagement by VHSNCs as these committees received the intervention to strengthen their functionality. This research included ongoing engagement with SEEK's staff over the

course of the intervention to understand their experiences delivering this VHSNC support package.

7.3.3 Data collection

This paper draws from in-depth interviews (IDIs) with SEEK's staff, VHSNC members, non-VHSNC community members, and health system actors; focus group discussions (FGDs) with community members; ongoing observation and informal discussion with NGO staff; as well as secondary review of written project materials (table 15).

We conducted more interviews with women (n=41) than men (n=33) because most village-level health and nutrition system actors with a stake in the VHSNC (ASHAs, anganwadi workers, and ANMs) were female. We also had more focus group discussions with women (n=11) than men (n=7) because male perspectives dominated during all public observations, including at VHSNC meetings.

While the majority of the in-depth interviews and focus group discussions were in our four case study villages, some respondents worked across multiple villages (the NGO staff, ANMs, ASHA supervisors, and BCMO). Observations of social mobilization and VHSNC activities were in the four case study villages but observation of NGO activities, VHSNC trainings, and cluster level meetings took place in Manujpur or other villages and included VHSNC members from across the 50 villages.

Most of the primary data collection was conducted by co-author GP, a 25-year-old male Hindi-speaking researcher who lived in Manujpur during the study. He has a master's degree in public health and was supported closely by the study's research associate (SM) and research coordinator (KES), as well as the broader study team of senior researchers at the NHSRC, PHFI, and Johns Hopkins Bloomberg School of Public Health. The interviews and focus group discussions were conducted in Hindi and translated and transcribed into English.

Table 15. Data collected and analyzed for this study

Data type	Data details	# of interviews		
		Male	Female	Total
74 in-depth interviews	• NGO staff	3	3	6
	• VHSNC members from general community	21	11	32
	• Health and nutrition system actors (ASHAs, AWWs, ANMs, ASHA supervisors, BCMO)	2	24	26
	• Non-VHSNC community members	4	1	5
	• Ward members (who are VHSNC members)	3	2	5
	Total	33	41	74
		# of discussions		
18 focus group discussions	• VHSNC members	4	8	12
	• Non-VHSNC community members	3	3	6
	Total	7	11	18
1.5 years observation	• NGO facilitator selection and training • NGO planning and debrief meetings • Social mobilization • VHSNC expansion • VHCNC member trainings • VHSNC meetings • Cluster level VHSNC meetings			
Document review	• NGO's monthly progress reports & final report • Educational materials used by NGO • VHSNC meeting minutes • Government-issued guidelines • Letters from VHSNCs to government			

7.3.4 Data analysis

The themes presented in this paper, on the role and experiences of an NGO implementing a government designed participatory intervention, are a subset of all the themes examined in a broader research study. The broader study was not specifically focused on NGO experiences, but instead explored VHSNCs as a social institution, and engaged community and health system actor perspectives on a wide range of processes (such as community embeddedness and inclusiveness).

Our analysis was guided by thematic network analysis (Attride-Stirling 2001), whereby a coding framework was developed, guided by our *a priori* theoretical interest in mechanisms that facilitate community participation through VHSNCs and ameliorated by codes that emerged from the data itself, including the challenges faced by the NGO facilitators. This coding framework was then applied to the text to enable us to group text segments into topics. We then read and re-read the data outputs as they were presented for each code and extracted the salient, common, and significant organizing themes. The organizing themes relevant to the NGO's experience implementing this intervention are presented as the sub sections in the findings section. We used the qualitative software ATLAS.ti for coding the text and generating code reports.

7.4 Results

We first briefly explain the context and ongoing challenges that SEEK staff navigated in order to implement this intervention, as well as the overall successes. We then highlight the key social processes enabled by the NGO's "in-between" status that facilitated community participation in the health system. In the third section we present the NGO's capacities and strategies that made these social processes possible. The final section explores the challenges and costs that the NGO bore as a result of implementing this intervention.

7.4.1 Project context and challenges

The NGO succeeded in reconstituting and training VHSNCs across 50 villages, and was able to facilitate monthly meetings in most villages throughout the intervention period. Nonetheless it encountered significant community hesitancy, which was reinforced by non-responsiveness by government providers and officials.

Community responses to the intervention, and to the SEEK staff who sought to implement it, were colored by a widespread sense that the government was inaccessible, unfair, and uncaring. While some communities responded positively to the idea of forming a village health committee and were welcoming to SEEK staff, in other cases people recounted past government failures and sounded weary of being asked to invest energy and hope in a new initiative after previous disappointments.

In several instances, efforts to mobilize communities to participate in the VHSNC were met with resistance and skepticism, at times bordering on hostility. An NGO facilitator described a community's unwillingness to support the initiative:

> There was restlessness among the people. They were not willing to sit patiently and listen to me… They were complaining that even after they have raised their concern, no one listens to them. They said that you or this committee cannot be of any use to us. (male, NGO facilitator, Muslim, IDI_NGO_01)

In another village, people angrily told him that "nothing ever happens" and said: "Even you will not turn up after this meeting" (male, NGO facilitator, Muslim, IDI_NGO_01).

SEEK adhered to MoHFW-issued VHSNC guidelines and used MoHFW designed handbooks and training manuals, which promoted VHSNCs as bodies that could monitor local health, nutrition, and sanitation services and coordinate local level action across public sectors. However, the VHSNC's mandate came from the MoHFW without official support from any other ministries or departments. An NGO facilitator explained their struggle to reconcile this theorized ideal of intersectoral collaboration with reality:

> It is like the government is running away from us and we want to work closely with the government… For VHSNCs there are six services at the village level, like anganwadi, ANM, mid-day meal [in schools], etc., that should reach people. Our aim is to make people aware and demand… The twist is that people have to seek these services from six separate departments, like health, education, water, whereas the project is only with the health department. (male, NGO manager, 50 years, IDI_NGO_02)

Several key determinants of VHSNC success lay beyond the control of the NGO. The untied fund of Rs. 10,000 (US $150) for each VHSNC failed to materialize over the course of the intervention. Despite repeated inquires, VHSNCs and SEEK staff could not determine why the money was being withheld and which level of government was holding the money. SEEK staff also tried, unsuccessfully, to secure formal government orders supporting anganwadi collaboration with VHSNCs. SEEK staff asked officials in the health department to speak to the Department of Women and Child Development, which oversees the anganwadi system, but despite several requests there was no evidence that this inter-departmental communication occurred.

Over the course of the intervention, officials in the panchayat, health, education, and many other departments frequently failed to reply to VHSNC requests or they promised improvements that never materialized.

7.4.2 Positive productive capacity of the NGO's 'in-between' status

Despite the difficulties discussed above, a number of positive processes were made possible by the NGO's "in-between" status as government agent and community advocate.

- **Enabling community voice**

SEEK staff were able to facilitate community access to government actors in ways that had previously not been possible. For instance, before the NGO became involved, few people in the village had ever spoken directly to a medical officer. The NGO staff found out the block chief medical officer's mobile phone number and got VHSNC members to phone him to invite him to meetings or follow up on requests. Through the NGO, community members learned about what services they should have been receiving in the village, as well as which department was responsible. One facilitator even encouraged VHSNC members to take the issue of water shortages to their state-level member of parliament. The NGO staff not only directed VHSNC members towards appropriate departments, but also facilitated the

communication through writing formal requests on the VHSNC's behalf, coaching VHSNC members on how to speak to government agents, and accompanying VHSNC members to deliver requests. An NGO facilitator described his efforts to encourage VHSNC members to speak to government officials, although he noted that community members still hesitated:

> We have told them whenever you approach someone with your problem, firstly you should introduce yourself stating which committee you belong to and then you should tell your problem. As per my observation, even after telling these things they are not able to do these things properly and feel hesitant to talk... (male, NGO facilitator, IDI_NGO_04)

VHSNC members noted that NGO facilitators played a valuable role in accompanying community members to meet with block level government health staff.

> Once I went with [NGO facilitator, male] to our MO [medical officer]… We went to him regarding our request to provide training for the ASHA. We also went for our Rs. 10,000 untied fund… So the MO asked why we did not come earlier, [if you had] your work would be done. So one day we went directly to [the city] hospital with the letter. So [NGO facilitator, male] helps us a lot. (Shadeeka, male, IDI_VHC_37)

While the VHSNC members valued having NGO facilitators present during meetings with health system officials, many of the requests, including the request for the untied fund, did not result in changes, at least during the research period.

NGO staff also led the process of helping VHSNCs write request letters to the government. Although the focus of SEEK's contract was to form, train, and support VHSNCs, within a few months of VHSNC activity SEEK staff began orienting many VHSNC meetings around writing request letters to government departments asking for service improvements. SEEK made and distributed official looking letter pads to each VHSNC and taught members how to compose request letters and where to submit them. In meetings, almost every issue discussed concluded with the act of writing a request to the government to address a village level problem. For example, in one cluster meeting (OBS_VHC_35) we documented seven issues in which the NGO staff became involved in trying to solve through writing letters: requesting various government officials to release the untied fund, restock ASHA drug kits, fill vacant ANM positions, build an anganwadi center in a village that did not have one, train the untrained ASHAs, and ensure that a postman delivered pension cheques to the elderly.

- **Facilitate understanding between health system and community**

The NGO used its "in-between" status to help the community understand some of the challenges facing health workers, as a mechanism to move beyond anger at individual government workers towards action at an administrative level. For instance, NGO staff explained to VHSNC members in a village with an empty health center that the doctor who should serve them had not abandoned his post but had instead had been shifted to the CHC.

The NGO coordinated cluster level meetings, in which representatives from 16 to 17 VHSNCs would come together to discuss their challenges and develop strategies. When the NGO was able to convince higher level health system actors to attend, the interactions between government and community opened up new possibilities for communication and accountability because of the meeting locations and the NGO's mediation. Where VHSNC members could only access the medical officers in their governmental or clinical spaces, the NGO brought these health functionaries to more neutral or community oriented spaces: the NGO's office and community centers. In these spaces, the interactions took place on the NGO's terms. The NGO director exhibited careful diplomacy in treating health system actors as respected guests, but was also able to engage them in exercises of public accountability. Health system staff were expected to answer community questions, for example about why VHSNC funding had not yet been released, why ASHAs had not been trained or equipped with drug kits, and whether vacant positions for ANMs and doctors would be filled.

While their answers were sometimes vague and rarely led to immediate tangible improvements, this dialogue between community members and government officials was nonetheless a first step towards improved accountability, and was made possible by the NGO.

Health system staff also worked through the NGO to try to build community understanding of their issues, and to engage the community in productive ways. At one cluster meeting, the BCMO explained to community members that he did not have the power to hire more staff for their health center and requested that communities put pressure on politicians to solve the staffing issue:

> The BCMO said, "Although I am the head of this CHC, some matters, like the appointment of doctors, are controlled by politicians. I can't authorize the appointment of doctors; all I can do is depute doctors from one institution to another within the CHC area. We have to keep on demanding services so that politicians will be become aware of the problem and will put pressure on the concerned ministries to solve those issues." (Observation note, cluster meeting, OBS_VHC_26)

- **Linking and bridging**

In addition to building community-government relationships, SEEK staff also linked communities to resources and support outside the public sector, through their knowledge of other foundations and charities in the region. In one instance, SEEK staff invited a representative of a district-level private foundation to a cluster meeting. This representative encouraged VHSNC members to write to the foundation head, a respected local doctor in a charity-run hospital, and ask for money to support their sanitation and health work. In a village where the school's midday meal program was not in operation, NGO staff also encouraged VHSNC members to write to a local CSR initiative that was providing what an NGO facilitator referred to as "very good meals" in nearby villages (observation notes, cluster meeting, OBS_VHC_34).

Through trainings and cluster-level meetings SEEK also created bridges between villages, enabling VHSNC members to meet and exchange ideas. The facilitators themselves served as bridges by moving between villages and bringing with them comparative perspectives. For example, in one VHSNC meeting where members complained that the committee was useless because the government was unresponsive, a SEEK facilitator told the story of a nearby village's VHSNC's successful work in improving teacher performance at a school.

- **Capacity building of government providers and officials**

Community level capacity building was an explicit component of their mandate. But the NGO staff recognized that health system actors and members of local government also needed training, since few were aware of the VHSNC or knew the committee's mandate. SEEK staff organized special trainings after the state-level elections to teach newly elected local representatives (ward panch and sarpanch) about the VHSNC. SEEK staff also invited ASHA supervisors, ANMs, and medical officers to VHSNC trainings and meetings, and tried to build their support and interest in responding to these committees. Unfortunately, lower-level health system functionaries and ward members lacked the capacity to fix the many village-level shortcomings—an issue that SEEK could not address.

- **Highlighting success stories**

SEEK staff encouraged VHSNCs by enabling cross-village sharing, so inactive or frustrated VHSNCs could learn about the small successes of other VHSNCs operating in the same context. In highlighting these success stories, the NGO was able to encourage VHSNC members and help them develop locally feasible action strategies—and also legitimize the NGO's promotion of VHSNCs as a strategy for improving village-level wellbeing.

7.4.3 NGO characteristics and strategies to increase the intervention's success

What enabled the NGO to bring about the positive processes discussed above? Here we identify several characteristics of the NGO and strategies used by them to try to increase VHSNC functionality, noting their trade-offs and risks.

- **NGO staff motivation**

Several SEEK staff spoke about the importance of community action in the public health system and expressed dedication to seeing the VHSNC strengthening intervention succeed. For example, the project director described her desire to strengthen the public sector.

> And SEEK is working to make the [public] system better… We want people to accept the system, work with it, understand it and own it. (female, 40 years, project director, IDI_NGO_07)

Over our observation period, the NGO staff consistently displayed high levels of commitment to seeing VHSNCs become functioning local institutions for community participation. They expended energy and time above and beyond the basic requirements to try to engage communities, train VHSNC members, and help the VHSNC improve village level health, sanitation, and nutrition services.

- **Respected interlocutor status**

As neither village residents nor government officials, NGO facilitators presented VHSNC members an opportunity to engage with a unique set of interlocutors. The NGO facilitators were in many ways local: they understood and identified with members of the community; people knew their family, caste, religion, and village. Yet they were outsiders who brought outside knowledge and had connections to government. Unlike government officials, they did not require formal interactions and were not seen to be consumed by the indifference and uncontrolled self-interest often associated with government officials. Accordingly, this "in between" position enabled NGO staff to work in communities in valuable ways.

In most villages, it was risky to openly discuss problems in frontline service provision, such as an anganwadi worker taking the supplementary food rations home with her. The positions of ward member, ASHA, and anganwadi worker were generally occupied by dominant families. It was very difficult for more marginalized community members to speak out against members of dominant families and for relatives to criticize one another. However, the NGO facilitators were often taken into confidence about these local issues by VHSNC members away from the larger group. Speaking to the NGO facilitator was a mechanism for taking some action against local service provision issues, which was less dangerous than reporting on one's peers to a government worker.

Sometimes NGO facilitators were then able to help address the problems by, for example, staying with the VHSNC members for anganwadi center monitoring immediately after the VHSNC meeting, instead of leaving the monitoring tool with the VHSNC members to complete on their own. Although the anganwadi centers did not appear to improve as a result of this NGO-supported monitoring during our research period, the NGO's involvement nonetheless enabled the shortcomings of the anganwadi center to be noted and exposed anganwadi staff and community members to a set of standards. Noting these shortcomings from a community perspective has the potential to improve anganwadi system accountability and service provision, if upstream officials become involved or if communities gain the capacity to resolve village-level service provision problems themselves.

Women, who were generally not able to speak in VHSNC meetings because of social norms prohibiting them from speaking in front of male relatives, found it socially acceptable to speak to the NGO facilitators, male and female alike. Women often had side conversations with the NGO facilitator that enabled the facilitator to present women's concerns and suggestions to the men at VHSNC meetings. For example, in a focus group discussion, a female VHSNC member explained, to general agreement, "We do not speak there [in VHSNC meetings] but speak quite a lot to the one who comes, [name of female NGO facilitator]" (Hanwari, FGD_VHC_11).

In some cases, the NGO facilitator would use his or her outsider status to press the female VHSNC members to speak at the VHSNC meetings in the presence of men,

overlooking the local prohibition. While this demand may have made the women uncomfortable, the women usually discussed amongst themselves and then got the ASHA to present their opinion, which the male VHSNC members seemed to accept. As discussed in chapter 6, this micro-violation of gender norms represented an acceptable level of risk for the women and was generally accepted by the male VHSNC members because men recognized that the NGO facilitator had forced the point (rather than the women themselves exhibiting boldness and a desire to be heard, which would be unacceptable) and because the ASHA spoke, which could be considered an appropriate and necessary act due to her government position as health worker. We learned that some non-ASHA women experienced verbal retaliation at home for speaking out in meetings or trainings, but ASHAs did not mention any negative consequences.

VHSNC members also noted that visits from outsiders elevated the VHSNC meetings above a normal community activity, which helped sustain interest. For example a male VHSNC member (Jhorkibas, male, Muslim, IDI_VHC_50) explained that the NGO facilitator "makes things lively." If no outside facilitator came, he and many others said, no one in the village would gather. Some community members felt that information from outsiders was given greater weight and was more socially acceptable than if it came from a village resident.

- **Leveraging relationships to meet program goals**

NGO staff described leveraging personal and professional relationships to meet the VHSNC program's goals. Some NGO staff had prior relationships with teachers and nutrition system staff because of earlier work on different programs. Staff drew upon these relationships of trust or obligation to strengthen the VHSNC. Involving actors from across departments without official documents of support depended entirely upon personal relationships. For example, NGO staff navigated around the state-level Department of Women and Child Development's lack of formal support by encouraging anganwadi workers to attend trainings on their personal time:

> Then we said, 'What if they come on off-duty hours?' So some of the anganwadi workers volunteered to come and engage in training on off-duty hours. They came because of our personal and organizational relationships (Male facilitator and manager, IDI_NGO_02).

At the village level, NGO staff sought engagement from local people, including elected government officials, through personal connections, earlier work on other projects, and shared local identity. When possible, NGO facilitators directly approached people in the villages who had been involved in earlier SEEK projects in the education and youth development sector. NGO staff would introduce the VHSNC intervention to those individuals and ask them to support the project. Some agreed

to participate because of their positive earlier relationships with the organization and the individual facilitators, particularly the SEEK manager.

Leveraging hard-won relationships to try to make the intervention a success was often necessitated by lack of coordination and agreement at higher levels of government. This strategy helped achieve program success by enabling the NGO to involve key community stakeholders, but also risked eroding NGO-community relationships if community members were disappointed.

- **Linking personal and organizational reputation to program activities**

In many cases, facilitators managed community skepticism by offering up their own assurance and character as a testament to their sincerity and the positive potential of the VHSNC. Facilitators thus staked their own reputation and word on the intervention's success. They promised that they would see the intervention through and that they would be available for the community:

> I promised them that I will come every month and also whenever they call me. I told them that I will stay in the village for a long tenure and will continue to come even after forming the committee. The villagers said let's see how many times you visit the village. I told them to trust me and I shared my phone number with them. (Male facilitator, IDI_NGO_04)

While the facilitator continued to visit the village for the 1.5-year intervention period, when the intervention ended he moved on to another job. The NGO facilitators gave the VHSNCs advance notice that their support was ending and sought to capacitate them to continue functioning without the NGO, but still worried that communities would see their facilitation as short-term and insufficient.

In villages where the NGO had previously worked in other sectors, NGO staff sought out community members who had been involved in these earlier projects and tried to convince them to join the VHSNC. Community members often reported that one reason they agreed to get involved was because they knew and trusted the NGO. Some community members also mentioned specifically trusting the SEEK manager, who had been working in the social sector there for many years, and knowing this NGO staff member's village roots and family reputation. For example, a male VHSNC member explained "With the help of [male NGO manager] from [village] we got involved in this committee because he is the son of a headmaster" (Hanwari village, male, FGD_VHC_06).

Having a good organizational reputation in many communities and a staff composed of enthusiastic local people were factors that made this NGO a suitable body to carry out this intervention. However these same factors opened up the NGO and individual staff to loss of reputation and status if community members felt disappointed in the intervention. NGO staff willingness to stake their reputation on

the intervention indicates how deeply committed they were to seeing the VHSNCs become active.

- **Emphasis on positive potential of intervention**

Their motivation to see the intervention succeed and their enthusiasm for VHSNCs led NGO staff to present the VHSNC to communities in a highly favorable light, with an emphasis on the committee's positive potential. While conducting community mobilization in the villages, the NGO facilitators encouraged people to get involved in the VHSNC by drawing mobilization messages from the MoHFW's guidelines, including telling people about their public health entitlements (such as the right to have a functional health center nearby). NGO staff presented the VHSNC as a means of getting the government to deliver on these promises. They also informed the community that the members of the VHSNC would be able to allocate a yearly Rs. 10,000 (US $150) untied fund.

NGO staff repeatedly told communities that they would have to take initiative themselves and did not explicitly promise any public health system improvements. However interviews with community members indicated that many people took away a message that the NGO would bring a great amount of positive change. For instance, a woman recalled that the NGO facilitator called them during social mobilization and said that the NGO "will make all the [health] facilities available" (Shadeeka village, women, FGD_COM_03).

It would be a naïve reading of the data to assume that the respondents truly believed an NGO would quickly fix all their problems. Nonetheless, we note that respondents did frame the VHSNC strengthening intervention as an outcome- rather than process-oriented program, focused on improving a range of public services under the leadership of the NGO. As the intervention went on, VHSNC members increasingly understood that SEEK was not going to bring outside resources to their village and that the meetings were supposed to continue without NGO support. Many members explained that they were not going to remain involved because "that discussion happens in every month but nothing is happening" (women, Shadeeka, FGD_VHC_05). Ensuring regular meetings was a key outcome according to the government contract, but was valued in communities only as a means to concrete improvements.

7.4.4 Challenges for NGO capacity and relationships

- **NGO became the face of the program but lacked control over many aspects**

Leveraging relationships, linking NGO reputation to the intervention, and energetically promoting the positive potential of VHSNCs became problematic for NGO staff when important aspects of the intervention did not go as hoped. Repeated failures led to disappointment for the VHSNC members and resulted in frustration,

which was frequently directed at the NGO staff. For example, some people questioned the honesty of NGO facilitators, who had said that the untied fund would be arriving in their accounts soon:

> Most of the committees have been there for one year. We told them that within two months they would get the untied fund as per the information given to us. So now the difficulty is coming as they are saying that you are lying to us… We ourselves don't have the answer about why it is not coming (Female, project director, IDI_NGO_07)

At other times people were frustrated that all their attempts to engage block level health system actors failed and held the NGO responsible:

> We are going to consult with CMO [Chief Medical Officer] but he is not listening to us. Then what should we do? …Here in the village malaria is spreading. We are associated with your committee; what kind of help can you offer us? (Hanwari village, male, FGD_VHC_06)

While communities disparaged the government for failing to provide services, over the course of the intervention they began directing frustration at the NGO

facilitators for breaking what they had understood to be a promise for major improvements in the village:

> *Respondent 3*: Initially he said, there will be a hospital and delivery can be taken place in the village itself but nothing happened.
>
> *Respondent 1*: Yes, nothing is happening. Once land for the hospital was discussed and my father in law had also shown them the suitable land for that hospital. But nothing happened…
>
> *Respondent 5*: Nothing is happening. He [NGO facilitator] just comes, does the meeting and goes back. (Shadeeka village, women, FGD_VHC_05).

Another respondent said that people were irritated by their NGO facilitator: "People say that she speaks too much and we go mad. She doesn't do any work related to development but only makes discussions" (Hanwari village, female, IDI_VHC_47).

The NGO facilitators never had any control over the construction of facilities or hiring health workers, and were themselves frequently rebuffed by block level health system actors. Their mandate was merely to form VHSNCs, train members,

and help VHSNC members conduct meetings. They had no control over how the rest of the system engaged with VHSNCs, yet found themselves desperately, and generally unsuccessfully, trying to facilitate positive government engagement with VHSNCs, which would in turn justify the NGO's promotion of these committees.

- **Efforts to sustain community trust may have reinforced community skepticism**

We observed the NGO staff engage several strategies to maintain their reputation or regain community trust in response to the many barriers that VHSNCs faced.

NGO staff often spoke to one another in front of VHSNC members about the government's rejection of the NGO's efforts. For example, the director expressed her frustration about the BCMO and ASHA supervisor in front of about 40 VHSNC members at a cluster meeting, highlighting that the BCMO and ASHA supervisor gave conflicting explanations for why they could not attend. The BCMO said that there was an important engagement for them that day, while the ASHA supervisor said the engagement happened one day earlier and that he was off work on the current day because of heatstroke. The SEEK director finished, saying:

> *NGO director (female)*: See, this is how these government people are supporting us. They don't want to come because they will have to answer to the public. (Observation notes from cluster meeting, OBS_VHC_34)

In other instances, NGO staff called government officials in front of VHSNC members, and showed the VHSNC that the government official could not be reached by phone or spoke to the government official and relayed the official's explanations for non-attendance or inaction. In this way, NGO staff showed VHSNC members that SEEK was working towards the same goals as the VHSNC. These public actions showcased the fact that the NGO was unable to bring about improvements and illustrated the NGO's community-aligned (rather than government-aligned) identity.

SEEK also sought to clarify and even downplay their role, by presenting their organization as a modest facilitator to the more important community-government relationship. For instance, VHSNC members angrily asked the NGO about why the VHSNC had not received any money and what the VHSNC was supposed to do when the government was not responsive. Some NGO staff responded by aggressively reminding VHSNC members that the issue is between the communities and the government. This excerpt from an observation note captures a typical NGO staff reaction:

> *VHSNC member (male)*: From the beginning you are talking about the untied fund but to date you have not given a single rupee.
>
> *NGO manager (male)*: That is your VHSNC and your money. So who should try to get the money?
>
> *VHSNC member (male)*: But you are saying that that money will come, so you are responsible for giving that money.
>
> *NGO director (female)*: We are not providing the money and it is not in our hands. The money should come from government and that is a matter between the government and VHSNC members. We are just a medium in between and we are trying to help you. (Observation notes from cluster meeting, OBS_VHC_35)

These NGO efforts to sustain community trust involved trade-offs: in showing the VHSNC members that the NGO was not at fault, the NGO both encouraged and discouraged sustained community participation in the public sector. They encouraged participation and ownership by emphasizing that communities had the right to demand their entitlements, including to approach government officials about services and to follow up about the untied fund. SEEK facilitators even

suggested the VHSNCs file a "right to information" request to find out where the money was. However, some of their efforts to sustain their community-oriented identity may have adversely affected community willingness to continue engaging in the committees. Emphasizing the challenges SEEK faced when trying to work with government made some VHSNC members wonder how the VHSNC could succeed if even the NGO staff were unsuccessful. In emphasizing village-level responsibility and action, SEEK may have inadvertently invalidated or glossed over the enormous challenges villagers were facing.

In writing petitions to the government on every issue, the NGO took the only clear action available to them and aligned themselves as community advocates. The act of writing petitions to the government at the end of meetings satisfied the short-term expectation from VHSNC members to see the NGO facilitator take some action. Nonetheless, the act of writing requests achieved near-symbolic status, becoming a representation of action, rather than meaningful action itself. The main outcome and action of NGO facilitators, and as the intervention was phased out, of VHSNC members themselves, was the creation of letters. With minimal government response to these letters, the short term satisfaction of "doing something" generally led to a longer term reinforcement of the government's inaccessibility and the community's ineffectiveness at resolving upstream public system issues.

- **NGO staff felt their work was under-valued and under supported**

NGO staff were concerned that the government-designed intervention underestimated the time and resources required for field activities. They spoke frequently about the immense amount of effort required to achieve program goals, and expressed concern that the time and resources allotted for their work by the government intervention were insufficient.

Social mobilization, for example, was envisioned as a mechanism to create widespread awareness in the community about the existence and mandate of VHSNCs, and provide an opportunity for interested community members to join. Properly introducing the concept of VHSNCs to entire villages required more visits, and at multiple times of day, than facilitators felt possible in the time allotted:

> You say you have to arrange VHC meeting in one day, but arranging meetings requires time and mobilization and it is possible that we need to go more than once…. Government needs to understand that they have to give priority to people. We work like that only. Government says work 10 am to 5 pm and finish everything. It becomes very rigid. (male, facilitator/manager, IDI_NGO_02)

Another facilitator reported feeling overwhelmed by a hostile crowd during a mobilization event and suggested that additional staff would have helped him: “It is not possible for a single person to handle so many people. Support could be in terms of additional staff to gather and counsel people” (male, facilitator, IDI_NGO_01). However, the NGO often lacked the time and human resources for facilitators to work in pairs.

Facilitators found that it was necessary to visit communities frequently to gain community trust and remind VHSNC members about upcoming meetings. NGO staff tried to visit the villages as often as possible, but struggled to pay for their transportation costs.

> The problem is that the worker should visit his area of work at least five times in 30 days so that he can develop a relationship with his community. People could have discussed their problems with him. The staff were not able to do this because the money given to them was insufficient. They thought it was a formality and they visited their work area only once. If they have to go a second time, they have to spend their own money. So to make this project successful, the salary structure of grass-root level staff should be improved; the staff will also get motivated to work and will visit the field again and again. (Male, facilitator, IDI_NGO_04)

Female facilitators were in a particularly difficult situation. They could not make use of the NGO-owned motorcycles, because it is unacceptable for women in this region to drive motorcycles. They had to walk or arrange to be driven by men.

In addition, the officially mandated period for VHSNC expansion, training, and support, was also seen as insufficient. NGO staff were concerned that VHSNCs would not continue to function once "handed back to the government" with NGO support removed.

> According to me if the project doesn't continue then there won't be any meetings or any other activities. It would become non-functional like before. Now that we repeatedly visit and persuade them so much we have been able to motivate them a little. It won't be possible in the future if they are not given any back up support. (female, NGO facilitator, IDI_VHC_05)

Many VHSNC members echoed this concern.

The NGO director also pointed out that the end of the project was a major challenge for their own organization's development. The NGO did not have enough money

after the VHSNC-support intervention closed to retain the staff, who had gained enormous capacity over the course of the intervention:

> I am seeing a challenge too that now this project is getting over… The passion and enthusiasm that is in them now… we don't have resources [to sustain] that… So I am feeling that perhaps it should not stop here. A lot of energy and manpower has been invested in this project… At this point of time they are emerging as trainers and if we leave those team members right now then our investment on manpower would be lost. (female, director, IDI_NGO_07)

Her concerns reflect the wider trend in NGO professionalization and funding-based expansion, whereby NGOs expand and then contract according to the availability of external funds, treating staff as interchangeable and dispensable (O'Reilly 2011).

7.5 Discussion

This paper highlights the challenges, trade-offs, and strategies enacted by an NGO implementing a government-designed health system intervention. The NGO worked within a difficult context of community mistrust and poor government responsiveness to successfully form and support VHSNCs over a 1.5-year period. As discussed, they helped communities voice their concerns to government officials,

and helped facilitate some understanding between communities and local level government functionaries. They built the capacity of some government officials to work with VHSNCs and helped link communities with one another and with other sources of non-governmental support.

Many of these positive processes were made possible by the NGO's respected interlocutor status in communities, pre-existing relationships, and willingness to "sell" involvement in the VHSNC as a mechanism for improving village-level health and wellbeing.

However, despite enabling some positive processes, concrete improvements in the villages were often far below community expectations. Government support for the intervention was considered inadequate by NGO staff and communities, particularly evidenced by the government's failure to release untied funds into VHSNC accounts, as well as poor cross-departmental collaboration, and poor response to VHSNC requests for improved services. NGO staff thus endured community frustration on one hand and rebuffs from lower-level government officials on the other, while feeling under-resourced and under-supported by their government contract. The NGO risked its reputation in communities by promoting VHSNCs without being able to control crucial aspects of the intervention's success—a fundamental issue with development contracts (O'Reilly 2011).

SEEK staff promoted a government-mandated process, asking communities to engage in a participatory initiative within parameters set by the government. By using the guidelines and handbooks developed by the government, the NGO became a conduit for government messages and values. Yet the NGO did not gain any of the power associated with government bureaucracy, such as access to information on disbursement of funds or special access to district levels of government.

Our findings highlight that understanding the changing role of NGOs in society at the micro-level, as played out in communities by frontline NGO staff, is more nuanced than a straightforward trajectory to depoliticization. Government contracts that hire NGOs to increase community participation in the public system, such as the one taken up by SEEK, can be enacted by fieldworkers in a manner that mixes a service orientation (e.g. providing trainings, facilitating meetings) and a civil society orientation (e.g. helping communities increase engagement with government officials).

Sustaining community participation in the VHSNC was contingent on community members seeing the VHSNC as a mechanism to improve local health, sanitation, and nutrition. Thus the NGO became increasingly oriented around working with VHSNCs to demand improvements to the public system (i.e. becoming more responsive to communities, delivering concrete service improvements). The NGO could not successfully fulfill their contractual requirements focused on changing community members (i.e. building their capacity and willingness to participate in committees)

without also taking up a civil society oriented role that worked on changing the system. While the NGO staff may have set out to deliver a series of technical inputs (trainings, community meetings), they ended up drafting letters to government departments, calling and following up with officials, and even suggesting that communities reach out to the media, file right to information requests, and meet their state-level member of parliament. The NGO facilitators sought to work within the parameters of their government contract to serve the needs of the community, particularly through attempting to hold the public sector accountable. They spoke frankly about the ways their efforts to spark hope in the communities were undermined by government short staffing and unresponsive officials. It became imperative for the NGO staff to facilitate small-scale political action in order to maintain the trust and participation of the VHSNC community members.

This case study demonstrated that NGO fieldworkers can thus advocate for community needs through micro-level political engagement while providing services required by government contracts. Miraftab expressed concerned that when NGOs provided services for governments they would shift from:

> … Social change through raising consciousness, demand making, and opposition with the government, to organizations that aim incremental improvement of the poor's living conditions through community self-reliance and formulation of workable solutions. (1997, p. 362)

The efforts of SEEK staff involved aspects of both: they encouraged community advocacy and demand making, while at the same time encouraging self-reliance by teaching new skills and encouraging some local monitoring and problem-solving.

However, this case study also highlights that NGOs take on enormous risk through engaging in these contracts, especially when formal government promotion of community participation (exhibited by the existence of these contracts and national policies) is not enacted in reality (exhibited by limited engagement with communities by lower level officials). NGOs are at risk of losing community trust and enduring distressing interactions with frustrated community members. SEEK's efforts to work alongside communities to change the system by demanding better services and seeking greater engagement with officials had limited concrete outcomes during the time period of this study. Mobilizing community members to engage with the government, without government efforts to engage with communities, placed the NGO in a difficult position. The intervention ended with many communities unconvinced about the VHSNCs' utility. This does not bode well for sustained community engagement in VHSNCs and may make it more challenging for SEEK to work with these communities on future initiatives.

This case study clearly illustrates that NGOs can be invaluable players in participatory development programs: they bring important and unique characteristics and strategies born of their position between communities and governments. However, NGOs need adequate time, resources, and support from the

government to generate positive processes that strengthen community-government relationships. They need platforms to convey their understanding of the political barriers to community participation to program developers. NGOs also need to proceed with caution to protect their organizational interests. It is important that NGOs thoroughly consider how to manage the challenges and trade-offs involved in working between government and communities when trying to strengthen community engagement in the public sector.

7.6 Limitations and opportunities for future research

This NGO contract was granted by the MoHFW's technical advisory body, the NHSRC. The purpose of the contract was to enable implementation research in order to derive lessons for scale up. It was thus atypical to regular NGO contracts granted by state-level ministries in several ways. First, it was more flexible than a typical government-NGO service contract, which may have improved some aspects of the NGO's experience. For example, this contract allowed the NGO to add additional rounds of training and social mobilization; typical government contracts would be less likely to allow for this flexibility. In addition, this contract was initially for one year only and was then extended (without additional money) for another six months. Typical government-NGO contracts generally close without extension and any remaining money would be returned.

This contract funded SEEK to support VHSNCs in a small-scale trial, in only 50 villages. In some ways this could have improved government support for the NGO because the NGO was able to write directly to health system officials at the national level—however SEEK still felt under-supported and did not feel able to access necessary information, such as why the untied fund was not released to the VHSNCs, as previously mentioned. On the other hand, some of the main issues that SEEK navigated, such as poor intersectoral collaboration, may have occurred in part because the intervention was operating on a trial basis. When rolled out across the country, higher-level collaboration across social sectors may be established.

At least one researcher from our team (co-author GP) was present throughout the intervention, which may have furthered SEEK staff's motivation to showcase high levels of success. However, we engaged in ongoing discussion with NGO staff to emphasize that our research was in no way evaluative—that we were seeking to understand field realities and barriers to success, to inform scale up. In our interviews and discussions with SEEK staff, the staff often restated this point, indicating that they understood the researchers' role. Moreover, staff were open to discussing their challenges with the researchers. Nonetheless, the presence of an embedded researcher cannot be discounted; the possibility remains that this may have energized and further motivated the team.

There are many opportunities for future research both on NGO-government contracting more broadly, and in follow up with this specific case study. We

identified increasing politicization through implementing a very specific type of government contract: one that sought to build community participation in the health system. It would be valuable to explore how other types of government contract influence NGOs' political readings.

Our understanding of the trade-offs and costs born by the NGO through this contract was limited by the duration of our research period. We finished data collection at the same time as the NGO's contract to support VHSNCs closed. Since then, most of the field workers had to leave the NGO because there was no additional salary support. It would be valuable to follow up with staff who remain to ascertain how this contract influenced NGO-community relationships while running projects in the future. Moreover, it would be fruitful to speak to the NGO staff about whether the NGO would work on a government contract again and, if so, what precautions or conditions they would seek.

7.7 Conclusions

NGOs have a valuable role to play in increasing community participation in government systems. They fill a unique position in society that enables them to work productively to strengthen community-government relationships. Frontline NGO staff can support communities in micro-level political processes by helping communities assert their rights to public services. This grass-roots political engagement is contrary to assumptions that NGOs are necessarily depoliticized and

"tamed" by development contracts. However, NGOs must recognize the risks and trade offs associated with trying to maintain an identity as community advocate while serving as a government contractor. The risks are particularly acute in contexts where the government system lacks the incentives and capacities to effectively respond to newly engaged community members.

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CHAPTER 8. CONCLUSIONS

8.1 Summary of findings

The popularity of health committees in LMIC health systems shows no sign of abating (Mdaka, Haricharan, and London 2014; McCoy, Hall, and Ridge 2011). In India, the MoHFW's *Guidelines for Community Processes* (MoHFW India 2013a) illustrate an ongoing interest in encouraging community participation through health committees, and even expands their recommended membership size from seven to 15. These committees have the potential to improve the lives of millions in rural communities, who remain in desperate need of basic health, sanitation, and nutrition services. Knowing more about the barriers facing these committees (chapter 5), the costs and opportunities they create for community members (chapter 6), and the challenges and trade offs experienced by NGOs seeking to support them (chapter 7) will enable policy and programming to be more responsive to difficult grassroots realities.

Chapter 5 identified the specific contextual features that challenged VHSNC functionality in our case study site in northern India. At the community level, it identified social hierarchies that made it difficult for women and some lower caste people to participate and that made community members reluctant to speak out about issues within the village. At the health facility level, it illustrated how a severely resource-deprived government health system curtails community attempts

at engagement. At the administrative level, it outlined challenges in cross-sector collaboration. It also highlighted the mismatch between community needs for outside inputs (particularly infrastructure development to improve access to water) and the VHSNC program's focus on small-scale village level activities to promote health, sanitation, and nutrition. It further emphasized the opaque government hierarchies, wherein VHSNC members and NGO staff often had no way to identify or access the officials in charge of specific services or activities. Lower level health system functionaries, who the VHSNC could directly engage, often lacked the power to improve services. At the societal level, despite decentralization reforms to the panchayat, the powerful local elected leader (the sarpanch) remained one step beyond the VHSNC's reach. Insufficient development of social services, most strikingly illustrated in the central government's failure to increase health spending beyond 1% of the GDP, has forced even the poorest rural people to buy basic services such as health care, water, and education in the private sector. The discussion section of chapter 5 presents a vision of what a more VHSNC-enabling context would require.

Chapter 6 examined how power inequalities are mediated through the VHSNC to create social costs and opportunities for participants. We identified some opportunities for the renegotiation of gender and caste relationships, although we noted that women and lower caste people were vulnerable to repercussions beyond the VHSNC. Power inequalities between communities and outside elites created a dominant "discourse of responsibility." This "discourse of responsibility" portrayed

VHSNC members as responsible for improving health, sanitation, and nutrition services. Some respondents rejected this discourse, explaining that responsibility for these services lay with powerful outside actors. Others accepted this discourse. However, to reconcile village-level responsibility with a lack of improvement, they blamed their peers as too selfish and lazy to perform their responsibilities. Whether accepting or rejecting the discourse, most community members felt that continued participation would not be beneficial.

Chapter 7 explored the challenges, trade-offs, and strategies enacted by the NGO implementing the government-designed VHSNC-strengthening intervention. It found that a number of beneficial processes arose from the NGO's "in-between" position as both community advocate and government helper. The NGO was able to support improved communication and understanding between community members and frontline government officials. They were also able to bring women's voices into the VHSNC and identify issues at the village level (particularly the anganwadi) in socially accepted ways. However, NGO staff were faced with community frustration and potential loss of reputation when material improvements and support (particularly untied funds) were not forthcoming. They were also rebuffed by some lower-level government officials and felt under-supported in their government contract. This chapter highlighted how NGO staff sought to maintain their community-oriented identity while working as government contractors. They did so by going beyond the delivery of community-focused technical inputs to supporting VHSNCs in government-focused political efforts.

8.2 Concluding points and implications

An anecdote from Sojjapur village provides a useful segue into this study's concluding points and implications for policy and practice. Sojjapur was the case study village with an empty PHC; the doctor assigned there had been relocated several times to other PHCs and the CHC in Manujpur. He was returned to Sojjapur briefly during our research period. But, after only a few days, again stopped coming, explaining that there was no reason for him to open the PHC since it had no medicine and staff.

A success for Sojjapur's VHSNC

After we closed data collection, Gupteswar met a male VHSNC member from Sojjapur village on a bus while travelling from Manujpur toward Delhi. During their conversation, the man informed Gupteswar that after months of frustration, the Sojjapur VHSNC had a major victory.

During their final NGO-supported meeting, the NGO facilitator suggested that VHSNC members visit the District Chief Medical Officer in the main city and submit a request that medicine be supplied to their PHC. The VHSNC did so, and just three days later, the PHC received a large supply of medicines, valued approximately Rs. 2,00,000 (US $3000). The doctor immediately agreed to come back to the PHC.

Gupteswar visited Sojjapur three weeks later to see for himself. He found the doctor in the PHC running an active out-patient department (OPD). He looked at the OPD register and noted that an average of 45 patients were receiving care from the doctor and free medicine each day. The doctor explained that although the PHC still did not have any equipment, he was making do for the time being.

After this success, the male VHSNC members convened another meeting (without NGO facilitation) and began focusing on acquiring land for the construction of a new PHC behind the current dilapidated one. They are now waiting for the government to respond to their request for land.

This anecdote provides grounding for several concluding points, with implication for policy and practice:

1. Participation as a process not an outcome

When our 1.5-year research period closed, VHSNC members in Sojjapur felt there had been little concrete benefit from the VHSNC. Yet, just a few months later, the VHSNC succeeding in re-opening their PHC and were working to acquire land for a new PHC building.

Community participation is process-orientated, non-linear, and works in complex ways over long time horizons (Rifkin 2014; Rifkin 1996; Ebyen 2005). Support for VHSNCs, and the assessment of VHSNC success, must account for the ongoing needs of communities and the often-slow pace of change in communities and government systems. VHSNC functionality may rise and fall as members rally around a specific issue then lose interest for a multitude of reasons. Participation through standard monthly meetings may never resonate with the seasonality of rural life and the issue-specific nature of community action (Nyamu-Musembi 2006). Our findings resonate with other researchers, who call for permanent, or at least longer term, support for VHSNCs to increase the likelihood that they survive the fluctuations in community enthusiasm and government responsiveness (Khanna and Pradhan 2013; FRHS 2010). This permanent support could be provided by NGOs or a cadre within the public system.

2. The role of NGOs

Sojjapur's VHSNC was formed and capacitated by SEEK. But importantly, SEEK staff went beyond delivering the straightforward intervention. They did not just train VHSNC members and convene meetings. They suggested and helped enact political strategies that enabled Sojjapur's VHSNC to successfully advocate for their PHC.

As illustrated throughout this dissertation, NGOs can play a valuable role in programs seeking to increase community participation in the public sector. The NGO's continuous effort to build community-government communication and facilitate VHSNC appeals to government officials enabled the Sojjapur success.

The NGO also managed within-community power inequalities and created space for these inequalities to be challenged through participation in the VHSNC. It is thus noteworthy that in Sojjapur, after the NGO's support ended, the first VHSNC meeting only included male members. There is an important role for outside facilitation in constructing alternative social spaces that enable marginalized people to gain voice and power. As noted in chapter 7, the Indian NRHM earmarks 4% of their budget for NGO contracts. Therefore it is important to better understand some of the trade offs involved in taking up these types of NGO-government contracts and explore ways to protect the NGO's staff and organizational interests.

3. Responsibility for social services

On one hand, Sojjapur's VHSNC achieved a major success in having medicines supplied to their PHC and having the PHC doctor returned. On the other hand, it is unacceptable that a PHC was deprived medicine and staff in the first place. Moreover, when Sojjapur's PHC doctor returned, he left an additional vacancy at the Manujpur CHC—the BCMO just reshuffles a woefully insufficient health workforce between health centers. Sojjapur's success raises many concerning questions: Why was the PHC allowed to fall into disrepair in the first place? Why did earlier requests for medicine go unanswered? Why was this PHC supplied medicine while many ASHAs, ANMs, HSCs, and other PHCs continue to lack medicine? What will happen next month?

The role of community participation (through VHSNCs) in improving rural health, sanitation, and nutrition remains unclear because of different answers to a crucial question: Where does responsibility for village health, sanitation, and nutrition lie? It seems both ethically unacceptable and ultimately futile to expect community members to take on total responsibility for demanding government services and solving health, sanitation, and nutrition issues themselves.

Higher-level officials are themselves constrained by bureaucratic issues and budget shortages (Haider et al. 2008; Bali and Ramesh 2015; George 2009). The type of local voluntary action that VHSNC members could take up, such as monitoring anganwadi centers and helping the ANM, still require upstream support. As noted

by Campbell *et al*. (2010), community mobilization efforts have often focused on helping the marginalized raise their voices, without adequate attention to building receptive environments to hear these community voices. Placing high responsibility on VHSNCs for demanding government services and improving health in their villages is not a feasible mechanism for sustaining the public sector. Moreover, as we discussed in chapter 6, when VHSNCs are unable to bring about change, this sense of unmet responsibility can have negative effects on community cohesion and collective identity. This study highlights the urgent need for more supportive contexts in which rural people can not only participate in health committees, but also access the power and resources to bring about actual improvements to their health and wellbeing.

CHAPTER 9. APPENDICES

9.1 In-depth interviews guide for VHSNC members

The in-depth interview guides changed slightly over the course of the research period, reflective of the iterative nature of qualitative research.

This is just a guide to help you cover these topics. You can change the order or skip questions depending on the interviewee's responses. Also, for each question, only use probes (bullet points) if they are required—and there is no need to use all the probes.

Domain/topic	Questions and probes
1. Personal identity	To start off, can you tell me a bit about yourself?
2. Village context	What are some of the best things about living in this village? What are some of the challenges and problems that people here face? What are the different communities in this area? How do these communities relate?
3. General about VHSNC	I'm trying to learn as much as I can about VHSNCs. Can you tell me about the VHSNC? • What kinds of things does the VHSNC do? • Why does it exist? • What kinds of things do you think the VHSNC should do?
4. Identity and VHSNC involvement	How did you come to be involved in the VHSNC? What do you do on the VHSNC? • What do people at home (husband/wife/in-laws/child) think about your being on the VHSNC? • How much time each month do you spend on VHSNC activities? Is this okay? • What are the good things about being a member? What are the bad things? • Can you tell me about a time when you were happy to be a member? Can you tell me about a time when it was not easy being a member?
5. Information on all the different members	Can you describe each of the VHSNC members to me? • What do they usually do and say at VHSNC meetings/events? • Are there communities that are not represented on the VHSNC? • Probe to explore relationships between members

Domain/topic	Questions and probes
6. Formation and training of the committee	When did you first hear about the committee? What did you think? How was the committee formed? Can you tell be about the trainings that the committee received? What did you like about them? What did you not like?
7. Untied fund	Tell me how the untied fund works • What is it used for? Who decides how to use it? • What are some good things about it? What are some challenges or issues?
8. Meetings and activities	Can you describe a typical committee meeting? • Where would it take place? What do you think about this location? • Who would be there? Who would not attend the meeting? • Who coordinates the meetings? • What kinds of things happen? What kinds of things are talked about? • What makes you happy to go to the meetings? What makes you not want to go? • Who mostly talks? Who mostly stays quiet? Why? Can you tell me about a time when the VHSNC tried to solve a problem? Can you tell me about a time when someone came to the VHSNC for help? Can you describe a typical Village Health Day? Is it easier for men or women to participate in VHSNC/village health activities? How come?
9. Monitoring	Is the VHSNC able to monitor health activities and services? [PHC/sub-center/AWC)? Describe how this monitoring works. What are some challenges? What is done with this monitoring data? How do you feel about this monitoring activity?
10. Planning	Have you ever been involved in health planning activities (Village Health Plan/Panchayat Health Plan/PHC health plan)? Who all attends the planning meetings? Who leads/coordinates? How useful is this? Does it address the real issues?

Domain/topic	Questions and probes
11. Interface between users and health services	When people get sick, what are some ways they get help? • What about when a pregnant woman goes into labor? • Do all the children here get immunized? How does this immunization happen? Tell me about how your child got his/her immunization. • What are some reasons that children here might not go to the ICDS center/AWC? • Have you experienced some good things about the health care services here (the clinics, sub-centers, AWCs)? What are some of the good things about the doctors, nurses or anganwadis? • Have you experienced any problems with the health care here? What are some problems with the doctors, nurses, anganwadis? • What is a typical visit to the PHC like? Have you noticed any changes in health services (PHC, sub center, behavior of staff, nurses, ASHAs) over the past few years? • What kinds of things have changed? Why? • What kinds of things do you wish would change? How could some of these changes be brought about?
12. VHSNC hopes and concerns	What do you think the VHSNC will do over the next year? What are the best things about the VHSNC? What are your hopes for the VHSNC? What are your hopes for your village? For your children? What are the challenges facing the VHSNC? What would help the VHSNC overcome these challenges?
13. Other committees	What types of organizations/groups/clubs/committees exist here? Probe, asking: "Can you think of any others?" For each organization ask: • What types of things does this group do? • What are their meetings like? • Who joins? Who does not join? Why? What are the benefits of participating? What are the problems this group faces?

9.2 Focus group discussion guide for VHSNC members

Focus group discussion guides changed over the course of the study. This guide is one example.

Part 1: Opening statements
Thank you for taking the time to join this group. I am ____, the facilitator who will guide this discussion. This is _____, the assistant who will help with notes and coordination. You are each experts on this village so I hope you will speak freely and comfortably. There are no right or wrong answers. We want to hear from everyone here.

- If you tend to speak a lot, remember to give other people a chance.
- If you are a quiet person, try to speak up so we learn your opinion.
- We are recording this conversation because it is hard to write down everything. So please speak one at a time and avoid having side conversations.
- Before we begin the discussion, we will go through the participation agreement form and answer any questions.

Part 2: Consent process & filling in the coversheet

1. Read the study information sheet.
2. Have everyone sign the consent form. While people are signing the consent form, the focus group discussion assistant can fill in the participant information on the coversheet.
3. Give everyone a copy of the information sheet and consent form to take home.
4. Ask "Are there any questions before we begin?"

Part 3: Discussion
As a way to capture group consensus, throughout you want to check: "Does everyone agree with this statement or conclusion?" Paraphrase finding then ask "Would everyone in the village agree with this statement/ conclusion?" "Who might not agree?"

Topic	Questions/probes
1. VHSNC general	Please introduce yourselves with your name and a bit about your involvement with the VHSNC How long has there been a VHSNC? What issues do you deal with on the VHSNC? Can you give me an example?

Topic	Questions/probes
2. VHSNC inclusiveness	What are some of the good things about being on a VHSNC? What are some of the challenges? What types of people join the VHSNC? During last three months who attended the regular monthly meetings? What special challenges are faced by women who participate in the VHSC? What about men? Marginalized people?
3. VHSNC formation	Tell me about how the VHSNC was formed. How did people learn about the VHSNC? What happened? How were members selected?
4. Untied fund	Let's talk about the untied fund: what are the good things about the untied fund? What are some challenges with it? How do you decide how to spend it? Can you give me an example? When the VHSNC spends money, whom do you report to?
5. VHSNC engagement with the community	How are decisions taken by the committee communicated to the community? How often? Is there any data collection done by the committee members to know the state of health services? If no why? If yes what did you do with the data? Tell me about a time when there was a problem and the VHSNC tried to help? Tell me about a time when someone came to the VHSNC for help. What happened? Are there any communities that do not come to the VHSNC for help?
6. VHSNC participation in village health activities	Tell us about the most recent village health day: what happened? What did you do? Are there any other village activities that you take part in?
7. Linkages between the VHSNC and PHC	To what extent does the medical officer or his/her representative (BPM/BCM/ASHA supervisor) support the VHSNC? Does she or he attend meetings? To whom do you submit the Village health action plan?
8. VHSNC and social determinants of health	What are some of the social problems in the village? Could the VHSNC address ay of these problems? If yes than how? If no why? What kind of support would be needed to address these problems?
9. VHSNC priorities	What are the goals of the VHSNC?

Topic	Questions/probes
10. VHSNC role and future	How do you think the public health system is changing? What is the National Rural Health Mission/MoHFW/Panchayat doing? What ideas do you have to make the people here healthier?

9.3 Focus group discussion guide for community members

Focus group discussion guides changed over the course of the study. This guide is one example.

Part 1: Opening statements
Thank you for taking the time to join this group. I am ____, the facilitator who will guide this discussion. This is _____, the assistant who will help with notes and coordination. You are each experts on this village so I hope you will speak freely and comfortably. There are no right or wrong answers. We want to hear from everyone here.

- If you tend to speak a lot, remember to give other people a chance.
- If you are a quiet person, try to speak up so we learn your opinion.
- We are recording this conversation because it is hard to write down everything. So please speak one at a time and avoid having side conversations.
- Before we begin the discussion, we will go through the participation agreement form and answer any questions.

Part 2: Consent process & filling in the coversheet

- Read the study information sheet.
- Have everyone sign the consent form. While people are signing the consent form, the focus group discussion assistant can fill in the participant information on the coversheet.
- Give everyone a copy of the information sheet and consent form to take home.
- Ask "Are there any questions before we begin?"

Part 3: Discussion

Topic	Questions/probes
1. Village general	What are some of the best things about this village? What are some of the challenges people here face?
2. Discussion about health and health issues (immunization, AWC, birth)	Let's talk about sickness and health: What types of things do people get sick with here? What can be done about these things? We're interested in talking about the clinics here. What are some of the things they do there? What type of people work there? What would a regular visit to the clinic be like?
3. Other committees that have existed here	What kinds of groups have there been in this village? Probe: Who was/is on that one? What did/does it do? What do people think about it? How did it start? Why? Tell me about a time when…

Topic	Questions/probes
4. General discussion about VHSNC	Can you please tell me a bit about the village health committee? What is this? What kinds of people should be involved? What kinds of things do they do? What do people say about their activities?
5. VHSNC mobilization, selection, training	How did people come to hear about the VHSNC? Tell me about that time. What did people think when they heard about it?
6. VHSNC inclusiveness and representativeness	Who participates in the VHSNC? Why do some people join and other people not join? Any there any people on the VHSNC from your community? If yes how he/she selected?
7. VHSNC selection/ formation process	Can you tell me about how the VHSNC is formed? Probe to hear the whole story on how it was formed "And then what happened?" "How did that go?"… Tell me some reasons a woman in a village may not to join? Which people joined? Why?
8. VHSNC action to improve community level health and responsiveness to problems	Can you tell me about a time when the VHSNC helped someone solve a problem? Did the VHSNC ever talk to you about health problems and needs?
9. VHSNC activities	Does the VHSNC provide awareness of government health programs and entitlements? How does the VHSNC aid in enhancing utilization of health services?
10. VHSNC activity for the future—hopes, plans	Think about this village or your old village five years ago and think about it now. What's changing in this village? What about in the clinic? [Probe: tell me about ASHAs? Health report cards?] What ideas do you have to make the village a place with less sickness? What could you do to help make things better?

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Zakus, J David L, and Catherine L Lysack. 1998. "Revisiting Community Participation." *Health Policy and Planning* 13 (1): 1–12. doi:10.1093/heapol/13.1.1.

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EXPERIENCE

Research Coordinator, Public Health Foundation of India 2013-2015

- Conducted implementation research on a village health committee strengthening intervention in rural India

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Research Associate, Youth Voices Research Group 2010–2012
Dalla Lana School of Public Health, University of Toronto, Canada

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London School of Economics, UK (six contracts)

Research and Writing Consultant, Support for Advocacy to 2009–2010
Training and Health Initiatives (SATHI), Pune, India

Research Coordinator, Interface HIV Project 2009
Biomedical Research and Training Institute, Manicaland,
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HONOURS AND ACHIEVEMENTS

Emerging Voices for Global Health, Cape Town, scholarship participant	2014
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Commonwealth Scholarship (full MSc funding), UK Government	2007–2008
Political Science Honours Essay Prize	2007
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PUBLICATIONS: ARTICLES IN REFEREED JOURNALS

George, A, Mehra, V, **Scott, K** & Sriram, V. (2015). Community Participation in Health Systems Research: A Systematic Review Assessing the State of Research, the Nature of Interventions Involved and the Features of Engagement with Communities. PLoS ONE 10(10): e0141091. doi:10.1371/journal.pone.014109

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longer? *American Journal of Tropical Medicine & Hygiene,* 88(6): 1109–1115.

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Campbell, C. & **Scott, K**. (2010). Mediated communication in promoting health-enhancing dialogue about AIDS. *African Journal of Rhetoric,* 1(2)*:*10-37*.*

PUBLICATIONS: BOOK CHAPTERS

Campbell, C. & **Scott, K**. (2012). Community health and social mobilization. In Obregon, R & Waisbord, S (Eds.), *The Handbook of Global Health Communication* (pp. 177-193). West Sussex, UK: Wiley-Blackwell.

Campbell, C. & **Scott, K**. (2011). Mediated health campaigns: from information to social change. In Hook, D, Franks, B, Bauer, M (Eds.), *Social psychology of communication* (pp. 266-284). Basingstoke, UK: Palgrave Macmillan.

PUBLICATIONS: OTHER

Scott, K. (2010). Understanding the Canadian, Thai and Brazilian universal healthcare systems: a focus on regulation and lessons for India. *Medico Friends Circle Bulletin*, August 2010 – January 2011, 342-344: 43-56.

CONFERENCE PARTICIPATION

George, A., **Scott, K.,** Garimella, S., Mondal, S., Ved, R. & Sheikh, K. (2015, March). A Narrative Review Of Contextual Factors Influencing Health Committees In Low And Middle Income Countries. Poster presentation at the 4th Annual PHFI Research Symposium, Delhi.

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Scott, K., Garimella, S., Mondal, S., George, A., Gaitonde, R., Raman VR & Sheikh, K. (2014, October). *Complex world, complex research: Reflections on multi-stakeholder collaboration for implementation research*. Poster at the Third Global Symposium on Health Systems Research, Cape Town.

Mondal, S., Sheikh, K., **Scott, K.,** Garimella, S., George, A., Gaitonde, R. & Ved, R. (2014, October). *The VOICES initiative to strengthen village health committees in two Indian states*. Oral presentation at the Third Global Symposium on Health Systems Research, Cape Town.

Scott, K., George, A., Garimella, S., Ameerkhan K., Mondal, S., T. Sharanaya, Kamal, J. & Sheikh, K. (2014, September). *Government helper and citizen advocate? A case study on the multiple roles and pressures facing civil society organizations implementing a village health committee support program in India*. Oral presentation at the Symposium on Global Governance and Commercialisation of Public Health, Delhi.

Scott, K., Garimella, S., Mondal, S., Raman VR, Gaitonde, R. & Sheikh, K. (2014, March). *Implementation research to strengthen community engagement through village health committees: A case study in multi-stakeholder collaboration.* Poster presentation at the 4th Annual PHFI Research Symposium, Delhi.

George, A, **Scott, K**, Guttierez, J, Ghosh, U, Waiswa, P, & Peters, D. (12 Oct-3 Nov, 2012). Assessing how community capability features in health systems research in low- and middle-income countries: A systematic review. *Future Health Systems. Global Symposium on Health Systems Research.* Beijing, China.

Campbell, C, Nhamo, M, Nyamukapa, C, Madanhire, C, **Scott, K**, Skovdal, M, Sherr, L, & Gregson, C. (22-27 July 2012). Social capital and AIDS competent communities: evidence from eastern Zimbabwe. TUPDE0105. *XIX International AIDS Conference*. Washington, D.C. USA.

Scott, K. (30 April 2012). Participant in roundtable author discussion at book launch of *The Handbook of Global Health Communication*. George Washington University, Washington DC, USA.

Scott, K. & Campbell, C. (6 November 2010). The role of activism and advocacy in tackling maternal mortality amongst poor women in India. *Reproductive morbidity and poverty conference*. LSE & Economic and Social Research Council, UK.

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Scott, K. (22 September 2009). Exploring the potential of CHW programmes to create health enabling contexts: A study of the ASHA programme in rural north India. *Creating contexts for successful community-led health interventions*. London School of Economics, UK.

PEER REVIEW

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ADDITIONAL SKILLS

- Proficient in **SPSS**, **STATA** & **MPLUS** statistical software, and **NVivo, Atlas.ti** and **Anthropac** qualitative data software.
- Strong **editing** skills and interest in magazine and newspaper production (eg. Editor-in-Chief, *Incite Magazine*, McMaster University, Hamilton, Canada, 2006-7).
- **Teaching** and **mentoring** (ex. Incentive Mentoring Program Dunbar High School mentor, Baltimore, 2011-2013, Mentor, Life Skills Club, Beormund School, London, UK 2007-8).